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E. H. B.

Presented to the
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July 14, 1905.

Meetings.
1901-1905.
V. 2.

TRANSACTIONS

OF THE

GYNÆCOLOGICAL SOCIETY

OF BOSTON.

"*The practice of physic chiefly consists in being able to discover the true curative indications.*"—THOMAS SYDENHAM, M.D., London, 1624–1689.

REPORTED BY

AUGUSTUS P. CLARKE, A.M., M.D.,

Secretary.

BOSTON:

PRESS OF DAVID CLAPP & SON.

1905.

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PREFACE.

THE Gynæcological Society of Boston was founded Jan. 22d, 1869, and is the first gynæcological society that was ever formed. It originally consisted of only eight members. The work undertaken was most important in its relation to the treatment of disease peculiar to women, and it has been eminently successful in stimulating the spirit for investigation into the causes of disease, and for the development and the adoption of surgical methods and procedures that have proved everywhere appropriate and successful in their results, not only in cases strictly gynæcological but in those pertaining to every other department coming under the surgeon's care.

A careful perusal of the first seven volumes of the Transactions, 1869–1872, shows that the work that was begun has been monumental in its results as does also that of the volume that appeared in 1889, besides the fact that there have been presented many able papers which have been read at various times, and the discussions that have been carried on both before and subsequent to this last date. The matters comprised within this publication are for the most part taken from the records of the secretary, and therefore any errors that may appear in the record of the discussions should be attributed to the seemingly difficult task of always interpreting correctly the expression of a speaker, especially when the remarks are presented in an extemporaneous manner.

It deserves to be mentioned that the society bears upon its rolls besides its Active Members, upwards of one hundred Honorary and fully six hundred Corresponding Members who have been distinguished in their respective departments of practice, and have been resident in the United States, in Canada, and in the European countries.

OFFICERS FOR 1905.

President.

George W. Jones, M.D. . . . . Cambridge.

Vice-President.

Mary E. Jones, M.D. . . . . Boston.

Secretary.

Augustus P. Clarke, M.D. . . . . Cambridge.

Treasurer.

Francis E. Carroll, M.D. . . . . Boston.

Committee on Nominations.

Henry O. Marcy, M.D. J. Henry Woods, M.D.
Augustus P. Clarke, M.D.

Pathological Committee.

John C. Irish, M.D. Albert L. Norris, M.D.
Elizabeth C. Keller, M.D.

Auditor.

Jesse F. Frisbie, M.D.

PRESIDENTS

From 1869 to 1905 Inclusive.

* Winslow Lewis, A.M., M.D., 1869, 1870, 1871, 1872, 1873.
† Horatio R. Storer, A.M., M.D., LL.B., 1878, 1879, 1880.
William G. Wheeler, M.D., 1881, 1882, 1883.
Henry O. Marcy, A.M., M.D., LL.D., 1884, 1885.
Henry M. Field, A.M., M.D., 1886.
Horace C. White, M.D., 1887, 1888.
W. Symington Brown, M.D., 1889, 1890.
Augustus P. Clarke, A.M., M.D., 1891, 1892.
John C. Irish, A.B., M.D., 1893, 1894.
Jesse F. Frisbie, M.D., 1895, 1896.
Albert L. Norris, A.M., M.D., 1897.
Albert H. Tuttle, B.S., M.D., 1898, 1899.
‡ Charles W. Stevens, A.B., B.S., M.D., 1900, 1901.
J. Henry Woods, M.D., 1901, 1902, 1903, 1904.
George W. Jones, M.D., 1905.

SECRETARIES

From 1869 to 1905 Inclusive.

Horatio R. Storer, A.M., M.D., LL.B., from 1869 to 1878.
George H. Bixby, M.D., 1878.
Henry M. Field, A.M., M. D., 1879, 1880, 1881, 1882, 1883, 1884.

* Died, 1875. After the service of Dr. Lewis, there does not appear from the records to have been any election to fill the vacancy, until 1878.
† Elected President Emeritus 1882.
‡ Died January 25, 1901, and Dr. Woods was elected to fill the vacancy.

* Herbert J. Harriman, A.B., M.D., 1885, 1886, 1887, 1888.
† Samuel N. Nelson, A.M., M.D., 1889, 1890, 1891, 1892.
Albert H. Tuttle, B.S., M.D., 1892, 1893, 1894, 1895, 1896.
‡ Charles H. Harwood, A.B., M.D., 1897, 1898, 1899, 1900, 1901.
Augustus P. Clarke, A.M., M.D., 1901, 1902, 1903, 1904, 1905.

TREASURERS

From 1869 to 1905 Inclusive.

George H. Bixby, M.D., 1869, 1870, 1871, 1872, etc.
Joseph G. Pinkham, M.D., 1878, 1879, 1880.
W. Symington Brown, M.D., 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888.
Charles W. Stevens, A.B., B.S., M.D., 1889, 1890, 1891, 1892, 1893, 1894.
W. Symington Brown, M.D., 1895, 1896, 1897, 1898.
Francis E. Carroll, M.D., 1899, 1900, 1901, 1902, 1903, 1904, 1905.

* Dr. Harriman died April 14, 1889. He had acted as assistant to Dr. Field during the year 1884.
† Dr. Nelson resigned 1892, and Dr. Tuttle was elected to fill the vacancy.
‡ Dr. Charles H. Harwood resigned May 1901, and Dr. Augustus P. Clarke was elected to fill the vacancy.

HONORARY MEMBERS.

Alexander, W.,	Liverpool, England.
Anderson, Jas. H.,	New York City.
Anderson, Jas.,	New York City.
Anderson, William,	Edinburgh, Scotland.
Apostoli, Georges,	Paris, France.
Atlee, John L.,	Lancaster, Pa.
Atlee, W. L.,	Philadelphia, Pa.
Baldwin, W. O.,	Montgomery, Alabama.
Balls, Headley W.,	Melbourne, Australia.
Bantock, George G.,	London, Eng.
Barker, B. Fordyce,	New York City.
Barnes, Robert,	London, Eng.
Battey, Robert,	Rome, Ga.
Beatty, T. E.	Dublin, Ireland.
Bedford, G. S.,	New York.
Bennet, James Henry,	London, Eng.
Borjalski,	St. Petersburg, Russia.
Bowditch, Prof. Henry I.,	Boston, Mass.
Bozeman, Nathan,	New York City.
Braun, Carl,	Vienna, Austria.
Breslau,	Zurich, Switzerland.
Brown Séquard, C. E.,	Paris, France.
Byford, W. H.,	Chicago, Ill.
Carpenter, Walter,	Burlington, Vt.
Chandler, J. L.,	St. Albans, Vt.
Channing, Walter,	Boston, Mass.
Churchill, Fleetwood	Dublin, Ireland.
Clark, Alonzo,	New York.
Clay, Charles,	Manchester, Eng.
Condie, D. F.,	Philadelphia, Pa.

Cordes, August,	Geneva, Switzerland.
Coventry, C. B.,	Utica, N. Y.
Crosby, Dixi,	Hanover, N. H.
Davis, John Hall,	London, Eng.
Didama, Henry,	Syracuse, N. Y.
Dix, J. H.,	Boston, Mass.
Doleris, Prof. F. A.	Paris, France.
Donders, Frans Cornelis,	Utrecht, Holland.
Dubois, Paul,	Paris, France.
Duncan, J. Matthews,	London, Eng.
Dunlap, Alexander	Springfield, Ohio.
Emmet, T. Addis,	New York City.
Engelmann, Geo,	St. Louis, Mo.
Eve, Paul F.,	Nashville, Tenn.
Flint, Austin,	New York.
Gross, S. D.,	Philadelphia.
Girdlestone, T. M.,	Melbourne, Australia.
Hardy, S. L.,	Dublin, Ireland.
Hecker, C.,	Munich, Germany.
Hewitt, Graily,	London, Eng.
Hodge, Hugh L.,	Philadelphia, Pa.
Hugenberger, Th. sen.,	St. Petersburg, Russia.
Jackson, A. Reeves,	Chicago, Ill.
Jackson, C. T.,	Boston, Mass.
Jackson, Prof. J. B. S.,	Boston, Mass.
Johnson, J. B.,	St. Louis, Mo.
Johnstone, Geo.,	Dublin, Ireland.
Keiller, Alexander,	Edinburgh, Scotland.
Keith, Thomas,	Edinburgh, Scotland.
Kimball, Gilman,	Lowell, Mass.
Klob, Julius,	Vienna, Austria.
Landau, Leopold,	Berlin, Germany.
Lawrence, A. E. A.,	Bristol, England.
Lee, Charles A.,	Peekskill, N. Y.
Linton, M. L.,	St. Louis, Mo.
Locock, Sir C.,	London, Eng.
MacCallum, D. C.,	Montreal, Canada.
March, Alden,	Albany, N. Y.
Martin, August,	Berlin, Germany.

Martin, Eduard,	Berlin, Germany.
McClintock, A. H.,	Dublin, Ireland.
McDowell, R. W.,	Montreal, Canada.
McNabb, John,	Woodville, N. H.
Meigs, Charles D.,	Philadelphia, Pa.
Meniere, P.,	Paris, France.
Meyer, Leopold,	Copenhagen, Denmark.
Miller, DeLaskie,	Chicago, Ill.
Miller, Henry,	Louisville, Ky.
Moir, John,	Edinburgh, Scotland.
More-Madden, Thomas,	Dublin, Ireland.
Nélaton, Auguste,	Paris, France.
Nelson, Daniel T.,	Chicago, Ill.
Nott, J. C.,	New York.
Nunn, Richard, J.,	Savannah, Ga.
Pallen, M. M.,	New York.
Parker, D. McN.,	Halifax, N. S.
Parker, Willard,	New York.
Peaslee, E. R.,	New York.
Perkins, Joseph,	Castleton, Vt.
Thornton, J. Knowsley,	London, Eng.
Toca, Marquis Melchor de,	Madrid, Spain.
Trenholme, E. H,	Montreal, Canada.
Tupper, Charles,	Halifax, N. S.
Veit, J.,	Berlin, Germany.
Von Kamfer, Dr.,	Hanover, Germany.
Vulliet, Prof. François,	Geneva, Switzerland.
Waddell, John,	St. John, N. B.
Warner, Levi F. (Founder),	Boston, Mass.
Wells, Sir T. S. Spencer,	London, Eng.
West, Charles,	London, Eng.
White, James P.,	Buffalo, N. Y.

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Abegg, Heinrich,	Danzig, Germany.
Adams, Zabdiel B.,	Framingham, Mass.
Allen, Nathan,	Lowell, Mass.
Aleyne, J. S. B.,	St. Louis, Mo.
Althany,	Halle, Germany.
Anderson, William,	Brigus, Newfoundland.
Andrews, E.,	Chicago, Ill.
Andrews, R. F.,	Gardiner, Mass.
Antisell, Thomas,	Washington, D. C.
Arching, J. H.,	London, Eng.
Armsby, J. H.,	Albany, N. Y.
Armstrong, J. F.,	Cleveland, Ohio.
Arnold, E. S. F.,	Yonkers, N. Y.
Arnold, R. D.,	Savannah, Ga.
Ashhurst, J., Jr.,	Philadelphia, Pa.
Askew, H. F.,	Wilmington, Del.
Athill, Lombe,	Dublin, Ireland.
Atkinson, William B.,	Philadelphia, Pa.
Ayres, W. O.,	San Francisco, Cal.
Babb, L. P.,	Eastport, Maine.
Bahnson, Henry T.,	Salem, N. C.
Bailey, William H.,	Albany, N. Y.
Bancroft, J. P.,	Concord, N. H.
Bancroft, W. W.,	Granville, Ohio.
Bantock, Granville G.,	London, Eng.
Barker, P. C.,	Morristown, N. J.
Barker, W. S.,	St. Louis, Mo.
Barnes, A. F.,	St. Louis, Mo.
Barnes, Joseph K.,	Washington, D. C.

Barnes, Robert,	London, Eng.
Bartholow, Roberts,	Cincinnati, Ohio.
Bartlett, Josiah,	Concord, Mass.
Bartlett, J. K.,	Milwaukee, Wis.
Bates, Julian,	St. Louis, Mo.
Batterman, H.,	Islington, Eng.
Bauer, Louis,	St. Louis, Mo.
Baumgarten, Gustav,	St. Louis, Mo.
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Baxter, J. H.,	U. S. Army.
Beach, Abijah I.,	Belleville, Ohio.
Beaumont, Eckhart L.,	Lavacca, Texas.
Beech, J. H.,	Coldwater, Mich.
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Bemiss, S. M.,	New Orleans, La.
Bennett, J. H.,	Edinburgh, Scotland.
Bernutz, Gustave,	Paris, France.
Berryman, John,	St. John, N. B.
Bezzi, Giovanni,	Moderna, Italy.
Bibbins, William B.,	New York.
Bigelow, H. R.,	Washington, D. C.
Bigelow, O. F.,	Amherst, Mass.
Billings, J. S.,	Washington, D. C.
Birnbaum, F. H.,	Cologne, Germany.
Bissell, D. P.,	Utica, N. Y.
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Blake, J. E.,	Middletown, Ct.
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Botsford, Le Baron,	St. John, N. B.
Bottini, Prof.,	Novara, Italy.
Boutelle, N. R.,	Waterville, Me.
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Boynton, Henry,	Woodstock, Vermont.
Bozeman, Nathan,	New York.
Bramlitt, W. H.,	Newbern, Va.
Brams, F.,	New York.

Braun, G.,	Vienna, Austria.
Breed, B. B.,	Lynn, Mass.
Breisky, August,	Berne, Switzerland.
Brickell, D. W.,	New Orleans, La.
Brickett, G. E.,	Augusta, Me.
Briggs, C. E.,	St. Louis, Mo.
Bright, J. W.,	Lexington, Ky.
Brinton, D. G.,	Philadelphia, Pa.
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Bullard, H. D.,	Findlay, Ohio.
Bullock, Otis,	Warren, R. I.
Bullock, William G.,	Savannah, Ga.
Bumstead, Freeman J.,	New York.
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Busey, S. C.,	Washington, D. C.
Bussell, John,	Portland, Me.
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Butler, S. W.,	Philadelphia, Pa.
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DeWolf, O.,	Chicago, Ill.
Dickson, John,	Baltimore, Md.
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Dirner, Gustav Adolf,	Buda-Pesth, Hungary
Dixon, R. M.,	Damariscotta, Me.
Dobell, Horace,	London, Eng.
Dohrn, Prof.,	Marburg, Germany.
Donaldson, F.,	Baltimore, Md.
Dowell, Greenville,	Galveston, Texas.
Drury, O. M.,	Orange, Mass.
Duffey, C., jr.,	Wilmington, N. C.
Dumortier,	Surinam.
Duncan, J. Matthews,	Edinburgh, Scot.
Dunlap, Alexander,	Springfield, Ohio.
Dunn, T. G.,	Newport, R. I.
Dunster, Edward S.,	New York.
Dutton, Charles,	Tyngsboro', Mass.
Dyce, Robert,	Aberdeen, Scot.
Earle, Pliny,	Northampton.
Echeverria, W. G.,	Mahopac, N. Y.
Eddy, M. H.,	Middlebury, Vt.
Edis, Arthur W.,	London, Eng.
Edwards, L. B.,	Lynchburg, Va.
Edwards, T. O.,	Lancaster, Ohio.
Eliot, Ellsworth,	New York.
Elliot, G. T., jr.,	New York.
Ellis, H. A.	Harrisburg, Pa.
Emmet, Thos. Addis,	New York.
Englisch, J.,	Vienna, Austria.
Erich, A. C.,	Baltimore, Md.
Fabbri, G. B.,	Bologna, Italy.
Failor, B. M.,	Newton, Iowa.
Fassett, Oscar F.,	St. Albans, Vt.
Fayé, F. C.,	Christiania, Norway.

Fenwick, G. E.,	Montreal, Canada.
Ferguson, Sir Wm.,	London, Eng.
Fernanti,	Ascoli, Italy.
Finn, N.,	St. Petersburg, Russia.
Finnell, Thos. C.,	New York.
Firestone, L.,	Wooster, Ohio.
Fisher, Geo. Jackson,	Sing Sing, N. Y.
Fitch, Simon,	Halifax, N. S.
Flagg, S. D.,	St. Paul, Minn.
Foote, G. A.,	Warrenton, N. C.
Forbes, D.,	Tallahoma, Tenn.
Ford, C. L.,	Ann Arbor, Mich.
Förster, August,	Jena, Germany.
Foster, T. S.,	Laconia, N. H.
Fränckel, E.,	Breslau, Germany.
François, Edward A. L.,	Saugus, Mass.
Frankenstein,	Jena, Germany.
Franklin,	Ipswich, Mass.
Fraser, J. B.,	Belfast, P. E. Island.
Fraylor, J. H.,	Cape Girardeau, Mo.
Freund, Dr.,	Breslau, Germany.
Frissell, John,	Wheeling, W. Va.
Gage, Thos. H.,	Worcester, Mass.
Gaillard, E. S.,	Louisville, Ky.
Gale, Geo. F.,	Brattleboro, Vt.
Ganser, W. L.,	Dresden, Germany.
Garrigues, Henry J.,	New York City.
Garraway, Edward,	Faversham, Eng.
Geddings, W. H.,	Aiken, S. C.
Geissler, A.,	Meerane, Germany.
Gerould, H.,	Massillon, Ohio.
Getchell, F. H.,	Philadelphia, Pa.
Getz, Hiram L.,	Marshaltown, Iowa.
Gibbons, Henry,	San Francisco, Cal.
Gibson, J. B.,	Dunham, C. E.
Giordano, Scipione,	Turin, Italy.
Gilbert, F. D.,	Sherbrooke, C. E.
Gluge,	Brussels, Belgium.
Goodell, Wm.,	Philadelphia, Pa.

Gordon, Prof. Seth,	Portland, Me.
Gotlf,	Prague, Austria.
Goupil, Enoch,	Paris, France.
Graves, J. G.,	Nashua, N. H.
Graves, J. W.,	Lowell, Mass.
Gray, George,	Nashua, N. H.
Gray, J. P.,	Utica, N. Y.
Green, John,	St. Louis, Mo.
Greene, W. W.,	Portland, Me.
Greeley, G. P.,	Nashua, N. H.
Greenhalgh, R.,	London, Eng.
Gregory, J.,	Munich, Germany.
Griffin, E. L.,	Fond Du Lac, Wis.
Grimsdale, T. Frederic,	Liverpool, Eng.
Griscom, J. H.,	New York.
Grout, G. F.,	Pulaski, Tenn.
Gunn, Moses,	Chicago, Ill.
Gusserow, Prof. A. L. S.,	Berlin, Germany.
Gusserow, Prof. D. A.	Zurich, Switzerland.
Habersham, J. C.,	Savannah, Ga.
Hadra, B. E.	Austin, Texas.
Hagon, C. J. O.,	Greenville, N. C.
Halbertsma, T.,	Utrecht, Holland.
Hall, Edward,	Auburn, N. Y.
Hall, J. V.,	Greensboro, N. C.
Hammer, A.,	St. Louis, Mo.
Hammond, Surg.-Gen. Wm. A.,	New York.
Harris, Augustus,	Colebrook, N. H.
Harris, R. P.,	Philadelphia, Pa.
Hart, C. A.,	New York.
Harvey, T. B.,	Indianapolis, Ind.
Hatch, F. W.,	Sacramento, Cal.
Hay, Thomas,	York, Pennsylvania.
Hays, Isaac,	Philadelphia, Pa.
Head, John Frazier,	U. S. Army.
Hegar, Prof. A.,	Freiberg, Germany.
Henning, Prof. Carl,	Leipzig, Germany.
Henry, W. J.,	Ottawa, Canada.
Herrick, H. J.,	Cleveland, Ohio.

Herrieux, ...	Paris, France.
Herz, Max, ...	Vienna, Austria.
Hewitt, Graily, ...	London, Eng.
Heywood, E. B., ...	Raleigh, N. C.
Hicks, J. Braxton, ...	London, Eng.
Hildebrandt, ...	Königsberg, Prussia.
Hildreth, C. F. P., ...	Suncook, N. H.
Hill; H. H., ...	Augusta, Me.
Hingston, Sir Wm. H., ...	Montreal, Canada.
Hitchcock, A., ...	Fitchburg, Mass.
Hitchcock, Homer O., ...	Kalamazoo, Mich.
Hjaltelin, J., ...	Reykjavik, Iceland.
Hodge, H. Lenox, ...	Philadelphia, Pa.
Hodgen, John T., ...	St. Louis, Mo.
Holton, Henry D.	Brattleboro', Vt.
Holt, Joseph, ...	New Orleans, La.
Hönig, H., ...	Bonn, Germany.
Hood, T. B., ...	Washington, D. C.
Hooper, F.	Fall River, Mass.
Horwitz, P. J., ...	Washington, D. C.
Hoscheck, ...	Landberg, O. S.
Hough, J. S., ...	Philadelphia, Pa.
Howard, Flodoard, ...	Washington, D. C.
Howard, R. P., ...	Montreal, Canada.
Howard, Wm. T., ...	Baltimore, Md.
Hubbard, J. C., ...	Ashtabula, Ohio.
Hubbard, Stephen G., ...	New Haven, Ct.
Hueter, Victor, ...	Marburg, Germany.
Huguier, B. C., ...	Paris, France.
Hunt, E. M., ...	Metuchen, N. J.
Hunter, S. B., ...	Machias, Me.
Hupp, J. C., ...	Wheeling, Va.
Huse, R. C., ...	Georgetown, Mass.
Hutchins, J. W., ...	S. Framingham, Mass.
Hutchison, J. C., ...	Brooklyn, N. Y.
Irvin, J. L., ...	Montgomery, Texas.
Jackson, Abraham Reeves, . .	Chicago, Ill.
Jackson, John D., ...	Danville, Ky.
Jacobi, Prof. Abraham, ...	New York.

James, J. W.,	Tarboro, N. C.
Jenks, Edward W.,	Detroit. Mich.
Johann, R. N.,	Chicago, Ill.
Johnson, Joseph Taber,	Washington, D. C.
Jones, H. W.,	Chicago, Ill.
Jones, James,	New Orleans, La.
Jones, N. E.	Circleville, Ohio.
Jordon, F, G.,	St. John, N. B.
Kammerer, Jos.,	New York.
Keeling, Jas. H.,	Sheffield, Eng.
Kehrer, F. A.,	Giessen, Germany.
Kellogg, J. H.,	Battle Creek, Mich.
Kendall, J. V.,	Baldwinsville, N. Y.
Kidd, Geo. H.,	Dublin, Ireland.
Kimball, Amy G.,	Jackson, Mich.
King, J.,	Wilmington, N. C.
Kinloch, R. A.,	Charleston, S. C.
Kleinwichter, Ludwig,	Prague, Austria.
Kraff,	Kieff, Russia.
Krassovsky, A.,	St. Petersburg, Russia.
Koeberle, M. E.,	Strassburg, Germany.
Kollock, P. M.,	Sanannah, Ga.
Kuhn, Dümas,	Salzburg, Austria.
Lambert, John,	Salem, N. Y.
Landi, Pasquale,	Pisa, Italy.
Landis, H. G.,	Columbus, Ohio.
Lane, James R.,	London, Eng.
Lange,	Heidelberg, Germany.
Langenbeck,	Hanover, Germany.
Law, Robert,	Dublin, Ireland.
Lazarewitch, Prof. J. de	Kharkoff, Russia.
Lazzati, P.,	Milan, Italy.
Learned, John B.,	Florence, Mass.
Lee, Charles, C.,	New York.
Leete, J. M.,	St. Louis, Mo.
Lehman, Albert,	Berlin, Germany.
Lehmann, L.,	Amsterdam, Holland.
Leishman, Prof. Wm.,	Glasgow, Scotland.
Lemercier, F. G.,	Paris, France.

Leopold, Prof.	Dresden, Germany.
Lindsley, Harvey,	Washington, D. C.
Litzmann,	Kiel, Germany.
Logan, C. A.,	Chicago, Ill.
Logan, T. M.,	Sacramento, Cal.
Logan, J. P.,	Atlanta, Ga.
Loomis, A. L.,	New York.
Loreta, Pietro,	Bologna, Italy.
Lucas, H. S.,	Chester, Mass.
Lusk, Prof. W. T.,	New York City.
Lyman, H. J.,	Chicago, Ill.
Lyons,	Surinam.
Lyster, H. F.,	Detroit, Mich.
Mack, Theophilus,	St. Catherine's, Canada.
Mackie, John H.,	New Bedford, Mass.
Macleod, G. H. B.,	Glasgow, Scotland.
Madden, T. M.	Dublin, Ireland.
Malagode, L.,	Fano, Italy.
Mann, Matthew D.	Buffalo, N. Y.
Marmon, P. de,	Kingsbridge, N. Y.
Marsden, Wm.,	Quebec, Canada.
Martin, Franklin H.,	Chicago, Ill.
Mastin, C. H.,	Mobile, Alabama.
Matsumoto,	Yedo, Japan.
Maughs, G. M. B.,	St. Louis, Mo.
Maury, R. B.,	Memphis, Tenn.
Mayer, Nathan,	Hartford, Ct.
Mayrhofen,	Innsbrück, Tyrol.
McCargow, Wm.,	Caledonia, C. W.
McClellan, Eli,	Fort Garland, Col.
McIntire, Harvey G.,	Concord, N. H.
McKeaguey, R. W.,	Halifax, N. S.
McNutt, W. F.,	San Francisco, Cal.
McRuer, Daniel,	Bangor, Me.
Meade, A. H.,	Bradford, Eng.
Meadows, Alfred,	London, Eng.
Meigs, M. R.,	Bedford, C. E.
Mendenhall, Geo.,	Cincinnati, Ohio.
Mercer, S. D.,	Omaha, Neb.

Mettauer, J. P.,	Prince Edward, C. H., Va.
Michel, R. F.,	Montgomery, Ala.
Miller, De Laskie,	Chicago, Ill.
Miller, J. P.,	Buchannon, W. Va.
Milne, Alexander,	Edinburgh, Scot.
Miltenberger, G. W.,	Baltimore, Md.
Miner, J. F.,	Buffalo, N. Y.
Mitchell, C. L.	Brooklyn, N. Y.
Mitchell, J. D.,	Jacksonville, Fla.
Mitchell, S. Weir,	Philadelphia, Pa.
Mitchell, W. S.,	New Orleans, La.
Moehring, G.,	Philadelphia, Pa.
Montgomery, Edward E.,	Philadelphia, Pa.
Moore, E. M.,	Rochester, N. Y.
Morrison, M. P.,	Monongahela City, Pa.
Moses, Prof. G. A.,	St. Louis, Mo.
Mouser, Silas M.,	San Francisco, Cal.
Müller, Prof. Peter,	Freiberg, Baden.
Mundé, Paul F.,	New York City.
Murray,	Newcastle, Eng.
Mussey, Wm. H.,	Cincinnati, Ohio.
Myrtle, J. Y.,	Edinburgh, Scot.
Napheys, G. H.,	Philadelphia, Pa.
Nash, Geo. W.,	Ottawa, Kansas.
Nebinger, Andrew,	Philadelphia, Pa.
Needham, W. C. H.,	Gallipolis, Wis.
Neftel, Wm. B.,	New York.
Nelson, A. W.,	New London, Ct.
Neugebauer, Prof. Ludwig A.,	Warsaw, Poland.
Newman, Robert,	New York.
Newman, W. H.,	Louisville, Ky.
Noeggerath, E.,	New York.
Norcom, W. A. B.,	Edenton, N. C.
Nussbaum, J. N. von,	Munich, Germany.
Nyrop,	Copenhagen, Denmark.
Oatman, Ira E.,	Sacramento, Cal.
Octerloney, John A.,	Louisville, Kentucky.
Olshausen, Prof. Robert,	Berlin, Germany.
Opie, Prof. Thos. D.,	Baltimore, Md.

Ordronaux, John,	Roslin, N. Y.
Paddock, Frank K.,	Pittsfield, Mass.
Page, D. A.,	Rutland, Vt.
Paine, H. E.,	Dixon, Ill.
Palfrey, Jas.,	London, Eng.
Palmer, A. B.,	Ann Arbor, Mich.
Palmer, C. D.,	Cincinnati, Ohio.
Panizzi,	Lugo(desRomaques), Italy.
Pantaleoni, D. C.,	Paris, France.
Panum, P. L.,	Kiel, Germany.
Papin, T. L.,	St. Louis, Mo.
Parsons, C. W.,	Providence, R. I.
Parsons, J. W.,	Portsmouth, N. H.
Parry, J. S.,	Philadelphia, Pa.
Parvin, Theophilus,	Indianapolis, Ind.
Payne, R. L.,	Lexington, N. C.
Penizzi, Domenico	Lugo(desRomaques), Italy.
Penrose, R. A. F.,	Philadelphia, Pa.
Pepper, Geo.,	Philadelphia, Pa.
Perkins, H. C.,	Newburyport, Mass.
Perry, C. H.,	West Medway, Mass.
Perry, Thos. W.,	Providence, R. I.
Pilcher, L. F.,	Brooklyn, N. Y.
Pinckney, N.,	Easton, Md.
Pooley, J. H.,	Yonkers, N. Y.
Porter, E. O.,	Cornwall, Vt.
Post, A. C.,	New York.
Potter, Thos. G.,	Providence, R. I.
Potter, Wm. Warren,	Buffalo, N. Y.
Prescott, D. S.,	Laconia, N. H.
Priestly, Prof. Wm. O.,	London, Eng.
Quackenbush, Prof. J. V. P.,	Albany, N. Y.
Ramsey, F. A.,	Knoxville, Tenn.
Reamy, Thaddeus A.,	Cincinnati, Ohio.
Reeve, J. T.,	Appleton, Wis.
Reimann, H.,	Kiev, Russia.
Richardson, B. W.,	London, Eng.
Richardson, Jos. G.,	Philadelphia, Pa.
Rizzoli, Francesco,	Bologna, Italy.

Robertson, F. M.,	Charleston, S. C.
Robinson, J. H.,	Southborough, Mass.
Robinson, Rienzi,	Danielsonville, Conn.
Rochartz, C.,	Cassel, Germany.
Rochester, T. F.,	Buffalo, N. Y.
Rokitanski, Prof. Karl,	Vienna, Austria.
Rosenthal, H.,	Berlin, Germany.
Rottot, J. P.,	Montreal, Canada.
Routh, C. H. Felix,	London, Eng.
Rowell, I.,	San Francisco, Cal.
Ruhstrat,	Göttingen, Germany.
Russell, R. H.,	Quebec, Canada.
Sabin, H. L.,	Williamstown, Mass.
Sabine, G. A.,	New York.
Sager, Abraham,	Ann Arbor, Mich.
Sänger, M.,	Leipzig, Germany.
Savage, Thos.,	Birmingham, Eng.
Savory, C. A.,	Lowell, Mass.
Saxinger, John,	Tübingen, Germany.
Sayre, Lewis A.,	New York.
Schatz,	Leipzig, Germany.
Schroeder, Prof.,	Bonn, Germany.
Schultze, B. S.	Jena, Germany.
Schwarz,	Göttingen, Germany.
Scott, A. J.,	Loudenville, Ohio.
Scott, John,	San Francisco, Cal.
Scott, M. T.,	Baltimore, Maryland.
Scribelli, Michele,	Naples, Italy.
Seguin, Edward,	New York.
Selden, O. G.,	Shanesville, Ohio.
Seller, Wm.,	Edinburgh, Scot.
Semeleder, F.,	Cordoba, Mexico.
Seniour, N. S.,	Salem, N. C.
Shiba,	Yedo, Japan.
Shrady, Geo. F.,	New York.
Sibbett, R. Lowry,	Carlisle, Pa.
Simon, G.,	Heidelberg, Germany.
Sims, H. Marion,	New York City.
Simpson, Prof. Alex. R.,	Edinburgh, Scotland.

Skene, A. J. C.,	Brooklyn, N. Y.
Skinner, Thos.,	Liverpool, Eng.
Smith, Albert,	Peterboro, N. H.
Smith, N. Lapthorn,	Montreal, P. Q.
Smith, Protheroe J.,	London, Eng.
Smith, T. C.,	Middleport, Ohio.
Smith, Wm. G.,	Chicopee, Mass.
Snelling, Frederick G.,	New York.
Snow, E. M.,	Providence, R. I.
Solowieff, Alex.,	Kasan, Russia.
Souchon, Edmond,	New Orleans, La.
Southam, Geo.,	Manchester, Eng.
Spanton, W. Dunnett,	Hanley, Eng.
Sparhawk, Thos.,	Amesbury, Mass.
Spear, D. D.,	Kennebunk, Maine.
Spiegeberg,	Breslau, Germany.
Stanton, J. O.,	U. S. Army.
Stearns, H. P.,	Hartford, Ct.
Stearns, John,	Boston, Mass.
Stevens, E. B.,	Cincinnati, Ohio.
Stiles, J. N.,	Windsor, Vt.
Stockton, T. C.,	San Diego, Cal.
Stoltz,	Strassburg, Germany.
Stone, Alex. J.,	St. Paul, Minn.
Storer, Ebenezer,	New York.
Storer, J. H.,	Triadelphia, W. Va.
Sumnerville, J. J.,	Salisbury, N. C.
Swayne, J. G.,	Bristol, Eng.
Tadlock, A. B.,	Knoxville, Tenn.
Tait, Lawson,	Birmingham, Eng.
Talbott, M. C.,	Warren, Pa.
Tarnier, Prof.,	Paris, France.
Tasker, B. F.,	Kendall's Mills, Me.
Taylor, R. W.,	New York.
Tewksbury, S. H.,	Portland, Me.
Thomas, Simon,	Leyden, Holland.
Thomas, T. Gaillard,	New York.
Thompson, Alex.,	Aurora, N. Y.
Thompson, A. W.,	Northampton, Mass.

Thompson, E. B.,	Marion, Ala.
Thompson, J. F.,	Washington, D. C.
Thornton, J. Knowlsley, M.B., C.M.,	Manchester, Eng.
Todd, S. S.,	Kansas City, Mo.
Tommasi, Salvatore,	Naples, Italy.
Toner, John Meredith,	Washington, D. C.
Turney, S. M.,	Circleville, Ohio.
Twitchell, Geo. B.,	Keene, N. H.
Tyler, John E.,	Somerville, Mass.
Tyng, Anita E.,	Providence, R. I.
Tyrrell, Gerhard G.,	Sacramento, Cal.
Upham, E. F.,	W. Randolph, Vt.
Van Bibber, W. C.,	Baltimore, Md.
Van Buren, W. H.,	New York.
Vance, Reuben A.,	New York.
Vanderpoel, S. O.,	Albany, N. Y.
Vander, Veer, A.,	Albany, N. Y.
Vandewarker, Ely,	Syracuse, N. Y.
Vanzetti,	Padua, Italy.
Vermyne, J. J. B.,	Voorst, Holland.
Volkmann, R.,	Halle, Germany.
Wagner, A.,	Kœnigsberg, Germany.
Walker, J. B.,	Thomaston, Maine.
Walker, Thos.,	St. John, N. B.
Wallace, Ellerslie,	Philadelphia, Pa.
Warner, Emerson,	Worcester, Mass.
Warren-Bey, E.,	Paris, France.
Watkins, E. V.,	Newbury, Vt.
Wathen, Wm. H.,	Louisville, Ky.
Weatherby, J. S.,	Montgomery, Ala.
Weber, F.,	St. Petersburg, Russia.
Weeks, Stephen H.,	Portland, Maine.
Weir, T. G.,	Edinburgh, Scot.
Wells, W. L.,	Howell, Mich.
West, Samuel,	Tiverton, R. I.
Whalley, Wm.,	Bradford, Yorks, Eng.
White, M. W.,	Salisbury, N. C.
Whitehead, W. R.,	New York.
Whitehill, J. C.,	St. Louis, Mo.

Whiton, H. B.,	Troy, N. Y.
Whittaker, J. P.,	Cincinnai, Ohio.
Wilder, Burt G.,	Ithaca, N. Y.
Wile, Wm.,	Newtown, Conn.
Willey, J. M.,	San Francisco, Cal.
Willey, Samuel,	St. Paul, Minn.
Williams, D. S.,	Freeland, Md.
Williams, J. J.,	Memphis, Tenn.
Williams, W. H.,	Shreveport, La.
Williamson, T. J.	Cincinnati, Ohio.
Wilson, J. G.,	Glasgow, Scot.
Winckel, Franz von,	Dresden, Germany.
Wingate, U. O. B.,	Milwaukee, Wis.
Winkler, N. F.,	Jena, Germany.
Wood, Wm.,	Portland, Me.
Woodward, John Janvier,	(U.S.Army)Wash'ton,D.C.
Woodworth, J. M.,	Washington, D. C.
Wooster, David,	San Francisco. Cal.
Workman, Jos.,	Toronto, C. W.
Wormly, Theodore G.,	Columbus, Ohio.
Worster, Joseph,	New York.
Worthington, E. D.,	Sherbrooke, C. E.
Wright, M. B.,	Cincinnati, Ohio.
Yandell, D. W.,	Louisville, Ky.
Yaqueth, Max,	Berlin, Germany.
Ziegler, Wm.,	Edinburgh, Scot.
Zini,	Gratz, Austria.

It was intended that a list of those who have been active members should also be presented in this volume, but inasmuch as a complete list from the beginning of the society could not be completed in season, it was deemed best to defer the matter to a subsequent issue.

TRANSACTIONS

OF THE

GYNÆCOLOGICAL SOCIETY

OF BOSTON.

Meeting October 9, 1901, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

The subject for discussion,

Fibroid Tumors of the Uterus.

Dr. Marcy prefaced his remarks by making reference to the early practice of abdominal surgery. He spoke of the difficulties that were encountered in undertaking the work and of the prejudice that was everywhere manifested to this new department of surgery. He made mention of the excellent pioneer work done in this direction by the late Dr. Burnham, and also of that accomplished by the late Dr. Gilman Kimball of Lowell, who performed 225 operations for ovariotomy with sixty-nine recoveries, and twelve operations for extirpation of the uterus with five recoveries. This was a most excellent showing of results obtained in such desperate cases as were undertaken by Dr. Kimball in that formative period of abdominal surgery.

Dr. Marcy, in giving an account of Dr. H. R. Storer's achievements, said that that surgeon was really the first to accomplish successfully the removal of the uterus. Dr. Storer's first success in the ablation of the uterus may have emboldened him as well as others at that early time too much in persevering in this line of operating, but the fact that a burdensome tumor could be safely removed proved most influential in helping to establish hysterectomy and the performance of other abdominal operations as proper surgical procedures.

Dr. Marcy spoke further of the good work that has been accomplished here in this vicinity, and he did not hesitate to say that Massachusetts by its early and continued successes had become the distinctive home of abdominal surgery. In this connection he spoke of the early management of the pedicle of the tumor by Dr. Storer, who brought the part upward and treated it extraperitoneally, leaving the ligatures out of the wound. Dr. Marcy thus early seeing the advantages of such disposition, reversed the method and so carried the pedicle downward, after sewing it off by the use of the tendon suture; he thus secured practically an extraperitoneal treatment. Hemorrhage preventing recovery was formerly a serious obstacle that had to be met. Such an occurrence can when aseptic animal sutures are properly employed be made a rare event. Adhesions that may result after abdominal operations should be prevented by careful introduction of a fine grade of sutures; these should be applied subperitoneally in such a manner that all incised portions of the peritoneum within as well as the pedicle itself may be completely turned backward so as to present a smooth and closed surface, leaving no points for subsequent hemorrhage and no places in which adhesions to other parts can take place.

Dr. Marcy then spoke pleasantly of the friendly criticism that he had always had from members of the Society, and he expressed his gratitude for the valuable suggestions that he from time to time had received; that, he said, had enabled him to carry on his work to a greater perfection. He referred to Lister's early use of animal ligatures. We first had cat-gut, now the kangaroo tendon; but whatever the animal suture may be it should be made thoroughly aseptic and applied as such, so that the incision can be closed and the sutures buried with perfect safety. In speaking of the removal of tumors he said that the uterus could sometimes be saved, but he thought that the practice gene-

rally would often prove not wise because the uterus was not unfrequently found to have become seriously infected, and this condition always greatly endangered the patient. When the uterus becomes the centre for the development of tumors it is not in a state to take on pregnancy. He showed a recent specimen of fibroids with complication of pregnancy; there was the wasted fœtus and the amnion showing evident traces of inflammation; parts were surrounded with clots. The uterus had undergone degenerative changes. The removal of the whole in mass afforded immediate relief. He showed a specimen of a uterine fibroid removed from a patient aged 72 years; the patient he found had previously been under treatment and she thought that she had been cured. She had of late had more or less flowing. The os and cervix were however nearly normal. It had also been suggested that she might have had cancer of the part. On opening the abdomen the disease proved to be a fibroid. He showed a number of other specimens of uterine fibroids that he had recently removed. He showed a small fibroid in the uterus that had been previously curetted by another operator. The appearance of the specimen made it evident to all that the operation of curettement in the case had been useless. He showed a specimen of uterine fibroid complicated with extrauterine fœtation. On opening the abdomen he had found that the Fallopian tube had ruptured near its fimbriated extremity; there was found an immense mass of blood with its fibrin that had been deposited in layers. The fibroid was thick and had become unusually indurated. The patient had been married three years and had had one abortion. In another case of uterine fibroid an ovary was found enlarged; this was due to the supervention of suppuration; the pus had undergone inspissation. To show the bad effects resulting from the use of buried silk sutures, Dr. Marcy exhibited a specimen of tissue containing a silk knot. A man some three months before had

had a testicle (left side) removed; soon after, the other testicle became the seat of painful trouble, and though the patient had been to two different hospitals for treatment he obtained no relief until Dr. Marcy cut down and removed a portion of tissue containing the silk knot that had been left. Dr. Marcy showed specimens of two cases of gall stones in which he had recently operated. In one of the cases there were upward of a hundred gall stones of varying sizes; in the other case there was one large and one small one.

Dr. Frisbie, in discussing the subject of uterine fibroids, made mention of a case of a young woman who had suffered for a considerable period from the effects of a large fibroid. This had been productive of pain and general prostration, and it ultimately was the cause of death. He advises removal before serious symptoms occur.

Dr. W. S. Brown made mention of Dr. H. R. Storer's first case of hysterectomy and said that though the operator had left only a small portion of the cervix, the woman, after the recovery of her health, continued to menstruate regularly; it was then surprising to consider that so small a piece of the uterus as was left had been sufficient for maintaining the function of menstruation. He said that Dr. Burnham was the first operator who was successful in removing the entire uterus. He further said that not every one of the pioneers of abdominal surgery was a model operator; he spoke of one of the earliest operators going to lunch in the midst of an abdominal hysterectomy.

Dr. Brown, in closing, remarked that fibroids are usually of multiple origin, that they occur for the most part in women who are forty years or more of age and that the preservation of the uterus in such cases is of minor consequence.

Dr. V. D. Miller, in speaking of uterine fibroids, said that she had seen tumors of this class presenting the size of

the fœtal head of the fourth or fifth month during pregnancy and that when there were no specially adverse symptoms she questioned the propriety of operating for their removal.

Dr. A. E. Miller said that he was highly pleased with Dr. Marcy's presentation of the subject. He reported a case of fibroid of long standing that appeared to give no trouble except from the size and tenderness of the tumor. He felt much in doubt whether growths of this character should be interfered with.

Dr. G. Ryder endorsed the views of Dr. Marcy, and remarked that in speaking of the development of fibroids it would be more correct to use the term "foci" than that of "focus" of invasion. In referring to the treatment by myomectomy he said that that method of operating often resulted in failure, owing to the occurrence of growths in other parts of the uterus.

Dr. A. L. Norris, who had had an extensive experience in the obstetric branch, reported a case in which a fibroid was located in the right cornu of the uterus. The patient was doing well; she has had two children. He thought that if physicians would look for such tumors they would find them oftener than they would have otherwise supposed.

Dr. A. P. Clarke, in discussing the subject before the meeting, referred to the methods of the French school as brought out at the International Medical meeting held in Paris, 1900. According to Monprofit and other French surgeons, hysterectomy has been a too common operation. Myomectomy is indicated for the removal of fibroids in young women who are desirous of fulfilling marital relations. Tuffier of Paris had reported 560 cases of myomectomy. He submitted the proposition that abdominal hysterectomy for fibroids should be the exceptional operation. Enucleation of fibroids, with preservation of the uterus and the "annexes," is the operation that should be

had recourse to. Two favorable factors come up for consideration; the first lies in the fact of the greater perfection with which he now operates; the second results from the less number of uterine fibroids that are now seen extending as high as the epigastrium. Enucleation, Tuffier remarks, is a slower and more difficult procedure. His success in myomectomy appears to have been phenominal; he has removed from one to seventeen fibroids from a single uterus. These have varied from the size of a hazel nut to that of a mandarine orange.

Tuffier speaks of having resorted to enucleation in 19 consecutive cases with 18 recoveries and with only one death. The contra-indications of myomectomy are manifest when the uterus has become the seat of a multiplicity of tumors which are in a varied state of telangiectasis or when the growths have become sphacelate and the disease is complicated with an irremediable condition of the adnexa. Advanced age of the patient may be an obstacle to recovery. In such cases total hysterectomy is to be preferred. His pupil Zvibel reported eleven cases of enucleation of fibroids complicated with pregnancy; the operations resulted in eleven cures with ten children born at term.

Dr. Clarke, in closing his remarks, said that his experience gained in his own work, as well as that obtained in cases seen with Dr. Marcy and with other operators, had led him to look upon enucleation as a less practicable method of treatment; it was very evident that none of the specimens of fibroids presented by Dr. Marcy at this meeting could have been safely enucleated. Tumors of the French women, he said, may be of a different grade from those met with in this vicinity; or it is possible that the more serious ones in Paris may have heretofore been removed. Though there was here, he said, a consensus of opinion upon matters of operating for fibroids, he thought nevertheless that the members of the Society should be

made aware of what was the trend of practice in this regard in other countries.

Dr. G. W. Jones was not in favor of myomectomy, on the ground that a greater amount of time was required for enucleation, and because of the greater danger from the effects of hemorrhage.

Dr. G. Ryder was opposed to myomectomy, for the same reason, besides, he looked upon the uterus and its appendages as being in cases of fibroids in a more or less diseased state.

Dr. Marcy, in closing the discussion, took the ground that aseptic wounds (and such we can often have) should not be drained. He spoke of cases of fibroids complicating pregnancy, and of one case in which delivery was delayed by the presence of a fibroid. When should we resort to myomectomy?

Dr. Marcy, in answer to this, said that his views in regard to operating were not so far from the French as were those of Dr. Jones. He spoke of the advantages, as had been pointed out by the Secretary, of resorting to myomectomy in cases of fibroids occurring in young women. In such cases, when the tumors are multiple comes the superiority of the method by abdominal section, for we have, as the French now operate, a better chance of saving the uterus. The thought to a young married woman that she can never become a mother is sometimes most horrible. He had seen cases of multiple fibroids resulting fatally because the patients had refused to have them removed. The greater the age of the patient, as a rule, the more becomes the danger of such growths.

In reference to the consideration as to the advisability of operating in any single case, the surgeon should first make a decision as nearly judicial as is possible. He should never urge an operation for the sake of performing it. The surgeon's reputation should be above suspicion. If the

disease when left to itself is likely to tend toward a fatal issue and there is on the other hand a fair chance for recovery if an operation is undertaken, then to decide against the measure would be a sin of omission. If the physician called is competent to perform the operation it is his privilege and duty to attend to the matter; if another is more competent, then if practicable the operation should be left to such a one. The medical attendant should not put himself forward too prominently. Consultation is often advisable. The surgeon should not operate that he may have the praise. The operator should be well prepared to meet any emergencies that may arise in a case; this should be so that a high standard of surgical skill may be maintained and that human life may not be trifled with. These are some of the canons that should be observed.

The meeting adjourned at 6 P. M.

AUGUSTUS P. CLARKE, M.D.
Secretary.

Meeting November 14, 1901, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

The subject for discussion,

Surgical Treatment of Diseases Connected with the Gall-Bladder,

Was opened by Dr. George W. Jones. Dr. Jones made mention of some of the important pathological processes that are met with in diseases of the gall-bladder and of their connection with disturbances of the function of the liver. So far as medical treatment was concerned, he said that only very little has been thus far accomplished by resorting strictly to therapeutical measures for such conditions. Obstructions affecting the gall-bladder are sooner or later liable to extend to the ducts, and when this happens the sufferings and dangers to which the patient is exposed call for more effectual and speedy relief. There is a considerable proportion of persons who become subjects of such affections. It has been said that the ratio is from twelve to eighteen per cent. Women have a greater proneness to biliary calculi than men; according to some authorities the difference is as six to one. This may be due to pressure caused by wearing tight clothing. Gall-stones are seldom found in people who dwell in hot or tropical countries. Persons may sometimes become affected with gall-stones and go all through life without giving any special indications of their presence; this is sometimes made evident by the fact of the physician's finding at an autopsy gall-stones in a case in which their existence before death had not been recognized.

Small biliary calculi may readily pass through the ducts when the parts are otherwise unobstructed. For the larger grade a surgical measure is the only remedy for permanent relief after internal medication has been fairly tried without success. It is only within a recent period that the surgeon has been enabled to realize the comparative immunity from danger attending such surgical treatment; this has been brought about by the perfection gained in antiseptic methods of surgery generally. The liver and the gall-bladder and its passages have within the past few years been the subjects of special clinical study. The most frequent demand for surgical treatment arises from the formation of calculi in the gall-bladder and their accumulation or impaction in the ducts.

While Dr. Jones would not deny that therapeutic agents for a cure would sometimes be of value, he emphasized the importance of the operator's obtaining special training and skill for carrying on surgical treatment for this class of diseases. Dr. Jones is decidedly opposed to the methods of treatment by aspirating or to any form of exploratory puncture of the gall-bladder. It has become well established that micro-organisms find their way into the gall-bladder; especially is this true in cases of empyema of the cyst or of its ducts; a puncture however minute may allow septic material to exude into the abdominal cavity and thus be productive of serious results. If it becomes necessary to open the gall-bladder the incision should be of sufficient size, and so made that the abdominal cavity may not be subjected to the dangers of infection. Dr. Jones then spoke of the great advances that had been made in gall-bladder surgery.

Cholecystotomy has received many new impulses since it was performed by Bobbs in 1867 and by Marion Sims and Kocher in 1878. In 1882 the operation of cholecystectomy, or the removal of the gall-bladder, was practised by Lan-

genbeck; that operator claimed that by this means all danger from biliary cystic formation would be prevented. Courvoisier, Sir Spencer Wells, Bernays, Küster, and Meredith were the first to perform the "ideal" method of operating for cholecystotomy; this was done by closing with sutures the gall-bladder and the abdominal wound without resorting to drainage. Dr. Jones regarded this as the best method of proceeding provided the condition of the parts admit of the practice; if, however, the walls of the gall-bladder have undergone contraction or have become unduly thin or fragile the suturing can only be imperfectly done. In such cases the final closure of the wound will have to be delayed to a subsequent date. The common duct from pathological changes not unfrequently becomes permanently occluded and a fistula may be produced; this may be successfully treated by attempting the operation of cholecystenterorrhaphy or of the establishing of a union of the gall-bladder with a loop of the intestine. This result, Dr. Jones remarked, was happily accomplished in one of his own cases. If the duct is so occluded that the calculus cannot be removed in the ordinary way the duct itself may be incised over the seat of the impaction, and after the removal of the obstruction the opening can be completely sutured, with the expectation of obtaining a good result.

After the diagnosis in any case of obstruction from gall-stones has been made, it is always well to decide, as far as possible, what should be the form of operation to be undertaken. In speaking of the method of opening into the duodenum he thought the necessity of that measure would rarely arise. In removing calculi from any of the ducts he considered it not wise to use much force in affecting their reduction. He has operated in thirteen different cases for the removal of gall-stones. In one of the cases he had to operate three times before he was finally successful. In this case he had a biliary fistula. Six months later he per-

formed cholecystocolostomy. The patient, about three and a half years after the last operation, died of marasmus. Dr. Jones remarked that the anastomosis was undoubtedly made too low down in the colon. The speaker regarded the immediate suturing together, when practicable, of the incised tissues of the gall-bladder without leaving the parts united to the peritoneum or to the abdominal parietes as the best method of operating. In performing the operation, he prefers the longitudinal incision; the point of election for doing this he finds immediately to the right of the rectus abdominis muscle. After opening the gall-bladder he explores it with the finger. It is always necessary before opening the cyst to search for adhesions and to overcome the same if possible. Upon the removal of the biliary calculi, the gall-bladder and its ducts should be washed out; the suturing being finally accomplished, the part is returned to the abdomen. In the operation for cholecystenterostomy he first raises with the point of the index finger a portion of the intestine to the gall-bladder and sutures the latter to it; he then makes an opening into the intestine. By this means he firmly buttons the gall cyst to the intestine. The speaker incidently remarked that gall-stones are not always productive of cholemia nor were their presence a frequent cause of cancer.

Dr. Godfrey Ryder, in discussing the subject, said that gall-stones may be occasionally due to the wearing of tight clothing; they have occurred as the result of a catarrhal condition. They have sometimes been formed from an excess of bilirubin which has been productive by oxidation of biliverdin. The most common cause, Dr. Ryder believed, was from the presence of bacteria which may have their starting point in the duodenum. Gall-stones that arise from bacteria occasion deposits of the bilirubin. Dr. Ryder spoke of the difficulties of always reaching a diagnosis. Clay-colored stools, tenderness over the site of the gall-

bladder and pain extending to the shoulder are important symptoms to consider. Age of the patient has not appeared to be a material factor. He advises early operating for their dislodgement. He compared to some extent the diseases of gall-bladder to those of the appendix vermiformis; in both, dangerous suppurative changes may occur. Operations on an old contracted gall-bladder are sometimes most difficult to perform; they are not infrequently more difficult to accomplish than are operative procedures for the removal of a pyosalpinx. By the early removal of biliary calculi the dangers of infection and of hemorrhage are much less. He referred to the danger of using force after adhesions have formed. Whoever, he said, resorts to gall-bladder surgery enters on a formidable task; in old cases a pericholecystitis is quite sure to be encountered. In such cases drainage will become indispensable, on account of the extreme dangers of infection that may have ensued.

Dr. A. P. Clarke said that the whole subject of gall-bladder surgery had been worked out during the later years of his professional career. Attacks of gastralgia, indigestion, dyspepsia, and nervous spasms may be due to the presence of gall-stones. Excessive diet, especially of animal food, he felt disposed to say had been a prolific cause. In operating, he did not regard the entrance of a small amount of bile into the abdomen as being so dangerous as had often been represented, nor did he see the necessity of resorting to drainage so often as some leading operators have advised. Of course in strictly suppurative cases or in cases in which injury to the gall-bladder or its ducts has occurred, drainage will be indicated. In the more recent cases, where cholemia and other more serious secondary changes have not occurred, we may look for early and favorable results by timely operative interference. Gall-stones in the common duct are liable to be overlooked. He considered the operation of cutting down and finding the gall-

bladder and draining it or its ducts after incision as not to be regarded for the most part a difficult procedure. To remove hard and firmly impacted calculi from the common duct without incision of this part of the biliary apparatus is quite another measure of operating. He readily recalled the experience which he had had in some of Dr. H. O. Marcy's cases, when that operator cut down and removed large and closely wedged calculi from the common duct without incising the duct and without finding it necessary to resort to drainage. Such had been his experience in his own cases. He believed the great success that Dr. Jones had had was largely due to his practice of dispensing with drainage of the gall-bladder. He could see not much more reason for incising the common biliary duct than he could for incising and draining of the penis in man for diseases of the urethra or for incision of the cervix uteri, as was formerly employed for certain affections of that portion of the genitalia. The use of forceps, scoop, dilators, and other such instruments for dislodging calculi from the ducts, is to be preferred. If the biliary ducts from the liver to the duodenum are rendered pervious, very little danger will occur from subsequent infection. In regard to the operation of cholecystectomy, as was first practiced by Langenbeck, Dr. Clarke remarked that such removal of the gall-bladder would at first thought appear to be a rational procedure and to afford protection against the occurrence of biliary cystic formations; this view would seem to be strengthened by the fact that the gall-bladder is not found in the ass, elephant, horse and rhinoceros, animals which are high in the scale of the mammalian class. Experience, however, shows that it is not alone in the gall-bladder that the biliary formations are met with; the more dangerous ones we now know are often found impacted in the hepatic and in the common ducts. The mere extirpation of the gall-bladder, without attention being paid to the concretions

occurring in the ducts themselves, would hardly be a justifiable method of proceding.

Dr. Jones, in closing the discussion, briefly remarked that what may sometimes seem to be a simple operation for the removal of calculi from the gall-bladder and its ducts may prove most difficult. He showed how tedious it was at times to get at the gall-bladder and to free it from its adhesions. The biliary products are liable to undergo septic changes and therefore the abdominal tissues should be guarded against such contaminating influences.

In answer to the question of Dr. W. S. Brown, and of others, as to the advantage to be derived by the use of large doses of olive oil, he said that in some initial cases the administration of oil is useful; he had used it he thought with some benefit. Chloroform, in doses of eight drops with two tablespoonfuls of the oil three times a day, had been a prescription of his. The great difficulty met with is in getting the oil into the biliary ducts. In old cases of impacted calculi he regarded the employment of oil as of no advantage. The meeting adjourned at 6 P.M.

AUGUSTUS P. CLARKE, M.D.
Secretary.

Meeting December 12, 1901, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

The subject for discussion,

Treatment of Recent Lacerations in Obstetric Practice,

Was opened by Dr. Henry O. Marcy. The speaker, in describing the female organs concerned in the processes of parturition, remarked that the structures entering into those parts had often failed to receive from authors the necessary attention which the intricacy of their histology and physiology would seem to demand. The study of the female genitalia, on account of the accidents to which they are exposed, may be considered in many respects of more importance to the physician than is that of the male. The speaker illustrated his remarks by making a drawing on the blackboard; the relation of the bladder and urethra to the uterus and its adnexa was uniquely shown. It was readily seen how that a descending head or other parts of the fœtus may during labor be productive of injury to the pelvic basin, to the vaginal introitus and to the perineal body. The relation and uses of the transversus perinæi, the levator ani or loop, and the sphincter vaginal muscles were commented upon. The importance of maintaining their integrity so as to preserve the necessary normal abdominal pressure and to prevent subsequent displacement of organs, were briefly but graphically set forth. He spoke of increasing the dangers of rupture by resorting to the old methods of so-called "supporting" the perineum during labor. In attempting to protect the perineum against rupture it is safer to press gently on each side toward the central portion of that body

than otherwise. The earlier treatment for the restoration of old lacerations was merely to denude or freshen the torn edges, then suture with silk or with wire the parts. Further experience had shown that it was essential to get to the torn muscles and to bring their severed parts together into their proper relation. If the fibres of the transversus perinæi are ruptured retraction of the ruptured ends will sooner or later take place, and this condition of the muscles is the cause of the eversion of the vulvo-vaginal opening. In closing a perineal rupture the structures should be brought into as near a normal relation as possible; he therefore advises for maintaining this the use of buried animal sutures. Dr. Marcy showed how liable the operator in failing to search for and to replace the divided muscular portions would be to have only a union of outer integument instead of the firm restoration of the tissues of the perineal body. Dr. Marcy spoke of the ease with which a diagnosis of perineal rupture can be made. This can sometimes be done by simply inserting the index finger into the rectum; the loss of the proper sustaining factors becomes immediately obvious.

Dr. W. Symington Brown, who had formerly had extended obstetrical experience, thought that much mischief had often been done by holding or pressing on the perineum. He said that very little advantage could be gained by the immediate suturing of torn parts after labor, on account of the tumefaction of the lacerated tissues. He regarded it preferable to wait two or three weeks before operating for closure. He spoke of the cases of women who were accustomed to work until within a short time of their actual confinement and of others who will not remain long in bed after such an event. The immediate suturing in such cases he thought would be of no practical service.

Dr. A. E. Miller spoke from his considerable experience; he said that he had obtained quite as good results by wait-

ing until the next day after delivery. Especially had he done so when the labor had terminated during the darker hours. By waiting, he said we can get better light to work in and can thus close the rents more satisfactorily.

Dr. Woods spoke of two cases in which he left the surgical treatment of the laceration until next day; he succeeded in both cases in obtaining good results.

Dr. Jones made mention of meeting in his practice of a considerable proportion of cases of "skin perineum." He thought the occurrence of such cases was due to the failure of the operator to recognize the true mechanism of perineal support. He advocated that all cases of primary rupture should be immediately operated upon. The exception to this should be made only in cases of extreme danger. He said that if the operator goes about the work in a proper manner good results could be obtained by attempting immediate repair, as by postponing to a later date. It is the skill of the operator that is most needed. He spoke of the paralyzed condition of the parts, that may remain for awhile after delivery; this will enable the operator to bring the ruptured ends together with greater facility. Before suturing all clots of blood should be removed, the surfaces should be cleansed and disinfected thoroughly; only continuous aseptic animal sutures, as Dr. Marcy had advised, should be employed. In case of failure, which in his experience had been rare, a secondary operation for repair can be had recourse to.

Dr. Augustus P. Clarke spoke of the importance of making a most careful investigation and study of the relation and action of the various muscles forming the perineal body. The action of the levator ani is to be especially considered. Any considerable injury to this muscle is liable to be productive of rectocele and to interfere seriously with the normal expulsion of the urine. Cystocele, as Dr. Marcy had alluded to, may be a troublesome result. It is

always necessary to maintain the continuity of the transversus perinei, for its action is to control the urethra and to render material support to the rectum and bladder. He agreed with the other speakers in the importance of exercising caution in attempting to support the perineum during the passage of the child through the lower pelvic strait. He instanced a case in which he was called to use forceps. After applying the forceps the head of the child was made to descend, and while the perineum was distending evenly and most satisfactorily, the physician who had been in attendance, becoming a little excited, suddenly placed his hand upon the perineum to render support, as he supposed he could do; this caused an immediate laceration of the entire perineal body. Dr. Clarke gave a word of caution against making pressure too near the rectum during the passage of the head from the vulva and while the perineum is being distended, for such pressure may be productive of spasm and of consequent laceration of the muscular structures. He favors taking steps for the immediate repair of the lacerated tissues. He made mention of a case in which he was called to suture together an extensive laceration, just after the delivery of a woman by the use of forceps by another physician. The employment of the anæsthetic was again resumed; the parts being cleansed by irrigating with warm sublimate solution, it was found that the rent had extended entirely through the perineum, through the sphincter ani, up through the recto-vaginal wall some three inches; both sulci were also badly involved. The application of continuous aseptic tendon sutures was made. Each sulcus was thus closed, then the recto-vaginal wall was sutured; this was the most difficult step in the operation because the parts were so jaggedly injured and the tissues so tightly retracted. The perineal body was firmly united by the same method of continuous suturing. The patient, though weak from previous loss of blood, quickly rallied and recov-

ered with a good perineum and with perfect closure of the rectal wall and anal rent.

Dr. Marcy, in closing the discussion and in reply to the question, when shall we operate on a recent laceration, remarked that it was safest to attempt immediate closure of the torn parts, for the longer we wait the greater is the danger of the occurrence of infection; he said that it is highly necessary to be scrupulously exact in determining the condition of the genitalia and in remedying defects after labor before taking leave of the patient; he also intimated that no particular feelings on the part of the medical attendant should be indulged in as that of not wishing to admit that a tear in his practice had taken place.

On motion of Dr. Clarke it was voted that Dr. Jones be a committee of one to provide for a supper for the January meeting.

On motion of Dr. Jones it was also voted that Dr. Marcy be the committee to bring in the list of officers to be chosen for the coming year.

The meeting adjourned at six P. M.

AUGUSTUS P. CLARKE, M.D.
Secretary.

Annual Meeting, January 9, 1902, 7.45 P.M.

held at

Hotel Brunswick, Boston.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

The report of the Treasurer, Dr. Francis E. Carroll, was read and approved. The report as presented had been duly audited by Dr. Jesse F. Frisbie, the auditor.

On motion of Dr. Clarke it was voted to accept the report.

The evening being the occasion for a dinner for the members, their ladies and invited guests, the meeting for business was adjourned, subject to the call of the president.

Dr. Samuel L. Dutton, one of the three surviving founders of the Society, organized on January 22, 1869, was present by the special invitation of the Secretary.

After the partaking of a bountiful repast which had been provided by the committee, Dr. George W. Jones, the President, Dr. Woods, read an interesting account of his visit to attend as a delegate the Twelfth International Medical Congress, which was held in Moscow, Russia, in August, 1897. Dr. Woods gave a description of the scenes and incidents met with along the route which he had travelled in reaching the ancient capital of Russia. His course on reaching Europe was through Greece and Turkey. He visited Athens and Constantinople. He passed through Austria and Germany; he stopped for awhile in Warsaw in Poland. He made particular mention of the character of some of the hospitals that he visited in those countries, and of the impressions that he had formed of the manners and customs of the people of those different nations. He spoke of the courteous reception given by the Russian officers of customs to visitors on

reaching their frontier lines. He spoke at some length of the opening of the Congress which took place in the grand opera house of Moscow; he spoke of the presence of the Grand Duke and of other imperial dignitaries who were in attendance on that occasion. The magnificence of the assembly seemed unprecedented. The dazzling and bejewelled uniforms worn by the great officers of state, the many renowned representatives from the various nations, the gorgeous apparel of the ladies, the dignified and eloquent responses made by members from the several different countries and given in various languages, intensified the scene and rendered the occasion an event never to be forgotten by those who had had the opportunity to witness the occurrence. He spoke somewhat of the character of the culture of the higher classes of Russia, of the ease and grace with which the ladies as well as the gentlemen could converse in various languages of other countries. Many of these people, he found, were quite familiar with leading English and American authors. He spoke from his experience of the contrast that there was between the accomplishments of the upper classes and of those of the lower grade. He made mention of the efforts the government of Russia had made for the entertainment of the members of the Congress and their ladies. Among other things mentioned he referred to the fact that the government had gone to great expense to transport from distant parts of the empire persons from various tribes and people who gave, according to their own peculiar manners and customs, striking exhibitions of the various dances and other wild-country performances. These scenes were given in the magnificent halls of the Chamber of Commerce, and were on such a colossal scale that it would seem to be quite impossible for the government of any other country to be able to offer a similar exhibition that would be so complete in all of its arrangements.

Dr. Konikow was then introduced. He said that he was

much pleased with the account of the recollections that Dr. Woods had given. He remarked that he was born in Russia and that he had visited Moscow. He felt that it was undoubtedly true that the upper classes in Russia were better practically educated than were the people in this country, but that there is a large percentage of illiterateness among the other classes. Careful study is paid by the upper classes to the acquirement of the mastery of the more important living languages and to other useful accomplishments.

Dr. Dutton, who was called upon, spoke in an instructive and touching manner concerning the opposition that was encountered in the organizing of the Gynæcological Society of Boston and in the carrying on of the work at that early period. He characterized the first secretary, Dr. Horatio Robinson Storer, as a man of great force in meeting and repelling attacks made upon the new organization. Those were times, continued the speaker, that tried the patience of the souls of those who had cast their lot with the new society. The meetings, he said, were nevertheless well carried on and were most instructive. Able papers were presented. Men of ability and large experience from other places were invited to appear; they generously responded to the call for contributions. The work of the founders was continued for some years. The journal of the Gynæcological Society of Boston was started in 1869 and was continued until 1872, when the transactions amounted to seven volumes. The editors were Drs. Winslow Lewis, Horatio R. Storer, and George H. Bixby. The papers and editorials were most interesting and spicy; they were not unfrequently referred to by eminent gynæcologists in this and in other countries. Prominent medical subjects besides those embraced strictly in gynæcology received their share of attention. The all too prevalent practising of criminal abortion received the mark of condemnation. The proper location of hospitals was another subject discussed.

The consideration of such themes became the pretext for considerable outside comment and much unpleasant and unjust criticism. The connection of the founders with the society was kept up until the health of all gave away. Dr. George H. Bixby has since died. The speaker, Dr. Dutton, had for some time been obliged to retire on account of ill health from active practice altogether. So had it been in the case of Dr. Henry M. Field. Dr. Winslow Lewis had died. Dr. John C. Sharp had also died. Dr. Storer has long been out of health. Drs. Levi F. Warner and William G. Wheeler, the other two founders, have died. Dr. Dutton was glad, he said, to see that the good work has still been going on; he expressed his best wishes for the old society's continued success.

Dr. Marcy was next called upon. He related some of the interesting experiences he had had with the members of the society. He recalled the occasion of his first meeting with Dr. D. Humphreys Storer, the father of Dr. H. R. Storer; this was almost at the beginning of his student days. Dr. Storer, senior, was then dean of the Harvard Medical School. From that time onward Dr. Marcy's acquaintance with the younger Storer became more and more intimate. He spoke of his own visit to Europe in 1869 and of his meeting Sir James Y. Simpson, the great instructor of the younger Storer. At that time diseases peculiar to women had been but imperfectly understood. Dr. Storer, he said, had been most instrumental in bringing to the attention of the profession the importance of a more careful study of such diseases. He spoke of the unjust criticism which had been made against the founders of the society. He remembered the enthusiasm which Dr. Storer, on his return from his foreign studies had shown, and of his getting reprimanded on one occasion while presuming to occupy during an hour of his teaching the professor's chair when at that time he was but a mere assistant

in obstetrics. The students, however, he said, could not see the necessity for the rebuke when they were receiving from Dr. Storer such new and very practical instruction in their medical courses. Dr. Marcy referred to the good work which the society had accomplished during the many years of its existence. He spoke of the pleasant feeling that had ever existed between its members and of the importance of maintaining such cordial professional relation.

Dr. W. Symington Brown was the next member to respond. He spoke in a most happy vein of humor. He had known from personal experience some of the obstacles the society had to encounter. He spoke further of Dr. Storer's early connection with the work that had already been mentioned. He referred to Dr. Storer's great teacher, Sir James Y. Simpson, who he said was the son of a baker of Bathgate, Scotland. The fact, Dr. Brown intimated, that Simpson had discovered the anæsthetic properties of chloroform required the exercise of much of the powers of that great Scotsman's genius to expose successfully the many fallacies of his would-be detractors.

Dr. Augustus P. Clarke being called upon expressed his appreciation of the success of the evening's entertainment. He had listened, he said, with much pleasure to President Woods' account of his visit to Moscow; he said that he could vouch for the truth of the statements which the president had made in reference to the extraordinary provision which the Russians at Moscow had made for the enjoyment and instruction of the visiting members. He said that the Russians had made great advancement in the art of medicine, that their hospitals are numerous and that they are fully abreast with the progress that had been made in this country. He spoke of some of the peculiar manners that were in vogue when meeting and parting with guests on state occasions; these after all have a salutary and refining influence on the visitors. The speaker then said that he

also had been much interested in reading and studying the life of Sir James Y. Simpson; his close sympathies with people had led him to take many a "wynd and stair" and to champion their cause in the relief of suffering. He believed that the spirit which had been begotten by this great leader and actor in medicine had in large measure been imbibed by his pupil, Dr. Horatio R. Storer. The speaker then referred to the most excellent work that had been done by the society; the many instructive papers that had from time to time been presented and the able discussions that had followed their reading. He referred to Dr. Storer's parting address, advising members to be faithful in attendance at the meetings and that each member should endeavor at least once a year to present a carefully prepared paper and to see to it that it was published in some good medical journal.

Dr. Clarke then made mention of the secretaries, his predecessors in office. Following Dr. Storer came Dr. Henry M. Field, a graduate in the arts and in medicine, and long a professor at Dartmouth College, a distinguished scholar and gentleman. Dr. Herbert J. Harriman, a Dartmouth graduate in arts and in medicine; a faithful secretary, Dr. Samuel N. Nelson an all-round Harvard man, a student afterward for some years under Prof. Koch in his laboratory in Berlin. He was an excellent microscopist and surgeon. Then came our genial Dr. Albert H. Tuttle, another all-round Harvard man with also a German training. The presidents, who have all done good work, have been not a few. It is not now necessary for me to name them.

Dr. Horace C. White, in responding to the invitation of the president, said that he recalled the names of many of the older members who have passed away. Drs. Henry A. Martin, William G. Wheeler, Henry M. Field, and Levi F. Warner were among the more active workers of the society. He spoke of the importance of the work that

had been accomplished and he expressed his intention of continuing his further attendance at the meetings.

Dr. Albert L. Norris spoke of his long acquaintance with many of the earlier members, and of his accompanying Dr. Marcy to Europe in 1869. He spent some time during his absence in Edinborough, where he met Sir James Y. Simpson and received from that great man most courteous attention. He said that Dr. Simpson inquired of him concerning some of the Boston medical gentlemen and remarked that he felt that much injustice, in reference to his claim to the discovery of the anæsthetic properties of chloroform, had been done him.

Dr. Tuttle was the last speaker. He referred to the good fellowship that had existed among the members, and of the encouragement that he had received in carrying on his surgical work. He said that the society had always been ready to recognize the value of good work and to promote their members for such cause. He remarked that the same could not always be said of every medical society, especially of one that he did not hesitate to mention.

The President then called upon Dr. Marcy, who had been appointed to nominate a list of officers for the ensuing year. The report presented was substantially a renomination of the officers who had been acting.

The list is as follows:—

For President, Dr. J. Henry Woods.
For Vice-President, Dr. Albert H. Tuttle.
For Secretary, Dr. Augustus P. Clarke.
For Treasurer, Dr. Francis E. Carroll.

For Committee on Membership:—

Dr. Henry O. Marcy.
Dr. Albert L. Norris.
Dr. Horace C. White.

Committee on Pathological Specimens:—

Dr. Henry O. Marcy.
Dr. George W. Jones.
Dr. Vesta D. Miller.
Auditor—Dr. Jesse F. Frisbie.

By vote of the Society, the Secretary, Dr. Augustus P. Clarke, was authorized to cast the necessary ballot for their election. The above were declared in accordance therewith to be duly elected.

On motion of Dr. Carroll a vote of thanks was passed to Dr. George W. Jones, for his excellent service in providing for a dinner. The meeting, after a most delightful and social entertainment, adjourned at eleven P.M.

Augustus P. Clarke, M.D.,
Secretary.

Meeting February 13, 1902, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

On motion of Dr. Francis E. Carroll, a vote of thanks was passed for the Secretary's full reports that he had made of the meetings of the Society.

A paper entitled:

The Treatment of Carcinoma Uteri when the Radical Operation is not Justifiable,

was read by Dr. Albert H. Tuttle. The writer began by saying what a picture this title recalls to one who has had much experience in cases of uterine cancer in which there have been long drawn out suffering, severe pains, foul discharges, alarming hemorrhages, the increasing irritation and discomforts which follow urinary fistulæ and rectal involvement. All these at times most unbearable. Then too, there is the cachexia, weakness, and emaciation steadily progressive until comes the final termination from all earthly suffering. The indications for treatment are presented in this clinical picture of carcinoma. Hopeless cases always demand measures for immediate relief from suffering. These may be medical and surgical. Opiates for controlling pain should be used. Small doses administered by the rectum are at times the preferable mode of employing them. Phenacetin and the coal-tar products may be tried, though the relief that they afford have been far from being satisfactory. By surgical measures, cauliflower growths and excessive granulations may be reduced. Acrid secretions may be lessened and much auto-infection prevented. The object of local treatment is to bring about, as far as possible, a

clean granulating condition of the affected surfaces. When the patient's strength admits, curettement under an anæsthetic should be tried. The base of the growth may be treated with caustics. Tincture of iodine, carbolic acid, or even a saturated solution of chloride of zinc may be used. The latter may be placed on a pledget of cotton and carried into the cavity of the ulcer; these may be repeated. The vaginal wall should be protected by vaselin and gauze. Hemorrhage following curettement usually ceases spontaneously. Ulcers can be kept clean by injecting slowly peroxide of hydrogen when the patient lies with the hips elevated. This may be supplemented by the use of a two-grain suppository of iodoform in cocoa butter. By this means irritation of the vagina and neighboring parts can be allayed. Hemorrhage appearing early may arise from the uterine mucosa similar to a form of menstrual disorder, or to a metorrhagia arising from or associated with uterine fibroids. Hemorrhage may proceed from broken down granulations and from ulceration of the uterine vessels. The first two varieties may be treated with advantage by curetting and by the employment of the actual cautery. Examination and local treatment of this character undertaken in many cases except under ether are liable to be imperfectly carried out and be productive of more or less unnecessary suffering. In some cases the most that can be done will be to keep the parts dry and to apply soothing ointments to the skin that becomes exposed to irritation. Opiates are usually sufficient to quiet pain or other serious discomforts. The bowels should be kept open by resort to saline laxatives. Stricture of the bowel with complete occlusion, though a frequent occurrence in cancer of the intestine, is fortunately a rare complication in uterine cancer. As the disease invades the vaginal tissue, infiltration follows after reaching to the perineum and tissues about the rectum; in such cases the parts become exeeedingly

sensitive. This condition may be treated by the use of cleansing solutions. Hot fomentations and bland unguents are useful. The writer next referred to the hypodermatic treatment by the use of various chemicals, such as oils and alcohol. With the knowledge of micro-organisms there have been attempts to associate the origin of malignant growths with the results of such agencies. If it were possible to show that micro-organisms take an active part in the production of cancer a local antiseptic or a constitutional method of treatment would be indicated as a logical plan of proceeding. The development of cancer does not preclude such a cause neither does microscopical research thus far disclose any such cause, and it is a matter of fact that we know but very little more now in regard to the primal causes of cancer than did our predecessors. The writer next referred to certain observations made by him during his early studies. He said that some years since while working in the marine laboratory of the late Professor Agassiz at Newport on a scientific study of the life history of the lunatio heros he had opportunity to observe changes in the growth and development produced by a changed and unfavorable environment. The eggs of the lunatio affected by abnormal temperatures, aëration, etc., instead of undergoing their usual cleavage and development broke up into erratic forms, hardly any two of them appearing alike. The cells in part were wanting in power of cohesion; they floated about in the nidus either singly or in bunches of variable size. In other instances double monsters were found, or the individual cells assumed unnatural shapes. The operation by which like produces like appeared to be reversed and to be in a state of anarchy and to end in the early destruction of the organism or in its reduction to a primitive form. At that time the writer believed that the cause of the changes was due to its unhealthful surroundings. He said that he was still inclined toward the

holding of that view. Whether or not the depressed vitality of the embryo allowed the introduction of other elements, such as the ingrowth of fungi which would act as secondary causes he was not prepared to say. In certain of the egg-cases mycelium was found. His observation on lunatio embryos has tended to cause him to hold to the theory that the development of cancer results from a change in the environment of a cell or a group of cells through which their normal growths becomes affected and through which their active proliferation contrary to the manner in which the more general operations of the elements composing them proceed. By this perverted modification they become as it were a band of out-laws that war upon their neighbors, and finally end their course in complete annihilation of the entire organism. . Once a cell or a group of cells has broken away from the influence that should control the whole, the progeny will inherit the force of its parent and will continue to carry on its warfare to destruction of the whole. A close study of the natural history of cancer shows that it simulates in many respects the progress and development of bacterial infection. The materies morbi travels along the lymphatic vessels, it produces enlargement, destroys parenchymatous tissue and rapidly reproduces itself. The observations thus made and the view here taken warrant a conclusion that a method of treatment by hypodermatic injections of antiseptic fluids is of possible value. The writer further remarks that such a theory of the origin of cancer harmonizes well with the fact that a growth arises in certain organs at a time when their functional activity is diminished or has ceased to be of service, that it often has its starting point at a site that has been subjected to continued irritation. Hereditary influence, as has been well observed, plays an important rôle in the causation. If such a theory of the origin of cancer is adopted it will be necessary to look upon the individual cells composing the neo-

plasm as foreign bodies and to regard them as holding the same relation to the body as do bacteria or amoeboid forms of life. To-day, operation for cancer of the fundus uteri by total hysterectomy is of positive value; the number of recoveries from the disease elsewhere being about fifty per cent., or a little more, if the operation is performed early. This does not hold true for the cervical form. The writer doubts very much if there is over ten per cent. of recoveries without future recurrence. Under these circumstances there seems to be but little to hope for in the advance of treatment for carcinoma unless it can come from constitutional or local medical methods. The writer feels that investigation and further observation should therefore receive encouragement in every way possible along this line of research.

Dr. George W. Jones said that it is generally known that cancer is the bane of humanity. In cases of so-called cures the question arises whether the diagnosis in such cases had been properly made. For several years the speaker had had his attention directed to the consideration of the development and of the treatment of cancer, but he was free to say that but little had been achieved by the way of effecting complete recovery. In cases of cancer affecting the skin, however, relief may be brought about by caustics. Epithelioma he said is fully as malignant as any other form of cancer; in such cases the employment of caustics rather irritate the parts than otherwise. The method which the speaker had adopted for the past few years consisted in the hypodermatic use of formaldehyde. Gelsemium and carbolic acid, and alcoholic injections he had also employed. In some cases he had felt that such treatment had been productive of relief and had appeared to have checked the disease to a considerable extent. Cancer, wherever met, is a most formidable disease and is one deserving the greatest attention by the physician.

Dr. E. P. Wing had seen cases in which repeated injections of formalin had been tried; the progress of the disease had nevertheless continued. Large doses of morphia had proved the best for relieving pain.

Dr. Francis E. Carroll said that it mattered but little in what part cancer has its starting point for it comes from some form of irritation. Over-excitation of the parts from smoking may produce cancer. Cancer of the uterus has been recognized as caused by such undue disturbances. The teaching of the schools gives a great deal of what appears to be cause of the disease, but many of the theories are of but little importance; it is largely through the exercise of the art of the surgeon that any considerable relief can be found. Injections, as mentioned, have not cured; they may serve to prolong life. Gelsemium and poke root (phytolacca), are cleansing agents, and that is the action of formaldehyde. For effecting permanent cure we shall have to look forward to future advances made in pathology.

Dr. W. Symington Brown, in discussing the merits of the paper, said that so far as pain is a symptom cases vary. The presence of cancer at first may not be attended with painful symptoms. Later, pain may occur if pressure becomes great on nerve tissue as upon that about the rectum. Dr. Brown spoke of some of the more troublesome sequelæ of cancer, such as vesico-vaginal fistula. He deems it best in hopeless cases of cancer to tell the patient, plainly what may be expected as to the outcome of the disease. Patients are often grateful for such full information. Dr. Brown made mention of a case which some years ago was seen in consultation with another surgeon. Dr. Brown, in that case, advised total hysterectomy but the consultant at that time hardly felt justified in attempting so radical a measure of treatment, and so only a partial removal of the uterus was effected. The disease returned. Dr. Brown reported five cases in which cancer had been removed and the disease did not return. Dr. Brown also made mention

of a case of cancer in which the disease had extended over a large portion of the face. The odor had become most offensive. In this case he used the actual cautery. It required nearly three fourths of an hour for its removal. The night following the patient was quite comfortable and for a while was much relieved. Cancer of the breast may be removed or cauterized with advantage for a time, even after the odor has become troublesome.

Dr. Augustus P. Clarke remarked that he had been particularly interested in what Dr. Tuttle had said in reference to the possible origin of cancer from the transmutation of a cell or a group of cells after they had broken away from their hitherto natural or apparently normal relation. He said that he welcomed of course the adoption of any line of investigation that might solve the mystery of the origin of cancer. He was inclined to believe that cancer is of bacterial origin and he felt from the efforts that are now being made that the time is not far distant when the question would be fully settled. He did not like to have the impression go out that no advance had been made as to the causation and the treatment of malignant diseases. We know, that as had been said, that continued and repeated irritation may be productive of cancer. Hence comes the necessity of attending to old and unhealed lacerations of the cervical tissue. Hysterectomy as had been advised by Martin, Olshausen, Freund, Saenger, and by others of the German school, has been productive in a considerable proportion of cases of excellent results. Later work in France, as well as in our own country and by our own confreres, had been of immense advantage to suffering women. So far as recovery from cancer is concerned by the use of proprietary medicines and by the so-called cancer cures he had the gravest doubts. If ever such supposed cases of cure by such treatment had taken place he had reason to believe the outcome had been the result of mistaken diagnosis, for

as yet we have not a complete knowledge of the distinguishing element, as we do have in cases of tuberculosis, diphtheria, and tetanus, for determining in every case an accurate diagnosis. In arriving at the diagnosis of cancer, much has to depend on the general judgment of the surgeon. The pathologist cannot as yet lay claim to perfect accuracy as to what constitutes the real unmistakable feature of cancer.

Dr. Jones remarked that it was true that a considerable advance had been made in our knowledge and treatment of cancer and in our ability to prolong life. He referred again to the advantage that may sometimes accrue by the use of a forty per cent. solution of formaldehyde.

Dr. Woods made mention of a case of cancer successfully treated by resort to radical surgical measures. He reported a case in which the patient remembered of her mother's being treated by a physician who used, she said, all sorts of washes and other applications. The patient thought the disease from which her mother suffered was cancer. If so, it was a record of cancer appearing in two successive generations.

Dr. Tuttle, in closing the discussion, made mention of a case of a woman that came under his care. After opening the abdomen and finding, as he then supposed, that the disease was malignant he went no further than to remove a specimen of it; this was sent to a prominent pathologist, who it appeared reported that the disease was cancer. The patient subsequently passed to the house of parties who claim to cure malignant disease by certain treatment or specifics. The patient seems to have apparently recovered, but as this was the only case of malignant disease which he could find that had recovered by the use of such pretended cancer curing remedies he could only conclude that the case which he mentioned was one of mistaken diagnosis. The meeting adjourned at 6 P.M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Meeting March 13, 1902, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

The subject for discussion,

Pelvic Peritonitis,

was opened by Dr. Francis E. Carroll. Peritonitis, according to the speaker, is the result of inflammation affecting the pelvic viscera. It is an inflammation limited strictly to the peritoneum of the pelvis. The disease presents symptoms peculiar to itself. The speaker then made brief mention of the earlier writers on the subject. He referred to the writings of Bichat in 1800, to those of Lisfranc in 1804, Nauche in 1816, Madame Boivin in 1828, and those of other writers who had made material contributions to our knowledge of the subject. The genital tract, as it has been called, is the prima via, or the direct channel, through which the disease may be conveyed, especially is it so at the time of parturition or at the occurrence of abortion. Disturbances taking place in menstruation may be productive of pelvic peritonitis. So also may metritis. Septic infection conveyed along the Fallopian tubes, or lymph channels, may give rise to such a condition. Such influences may have their starting point in a para- or periuterine inflammation, and from abscesses. Peritonitis may be the sequel of an ovarian cyst. A tubal pregnancy may be an exciting cause. A psoas abscess may lead to inflammation of the peritoneum. Salpingitis and ovaritis may become disturbing factors. The disease has its various stages. Congestion of the parts and exudation of coagulable fibrin and the formation of blood clots are some of the predisposing causes. Adhe-

sions formed become troublesome complications. Inflammatory œdema of the walls may cause considerable increase in the thickness of the parts. A circumscribed peritonitis and the formation of adhesions, "walling off of the exudate," are conditions not infrequently met with. In some instances the exudate may become absorbed or it may degenerate and then be productive of an offensive or sanious fluid, characteristic at times of septic peritonitis. Attacks of gonorrhea are prolific sources of such inflammation. Ovarian inflammation, whether primary to the peritonitis or as a complication to salpingitis, is occasionally difficult to determine. The escape of fluids into the peritoneum, as those of a pelvic abcess, or of a ruptured ovarian cyst, or of fluid from a traumatic injury, is not uncommonly observed to have taken place. Another exciting cause is sometimes found in the occurrence of tubercular deposits and from the extension of cancerous growths from neighboring parts. Uterine displacements of long standing are liable to give rise to pelvic peritonitis. Pelvic peritonitis may be preceded by a mild chill only, or a sensation of coldness about the hypogastrium. Pain is often the first indication. It varies; at times it is severe and even agonizing in character; at other times it is quite moderate. As a rule there is much uneasiness, or a weight and a sensation of dragging felt in the pelvic organs. The pulse in severe cases may be considerably accelerated, varying from 110 to 120 per minute. As the pulse increases it may become smaller or more tense or wiry. In cases approaching a fatal termination it may reach from 140 to 160 or more a minute. In many cases the temperature is high. A case commencing with a high temperature, say 104° or 105,° should be looked upon with suspicion, since it may assume a dangerous type. As the disease draws towards a fatal stage the temperature may become subnormal. Digital examination affords the means of expediting a diagnosis of pelvic peri-

tonitis. In the milder forms of peritonitis the disease may disappear without its being recognized; in other instances a local discomfort, uneasiness and pain occurring at the menstrual period may be experienced. This may be attended with febrile disturbances. It is not infrequent for the surgeon to meet with a case in which the uterus or its adnexa may have become adherent or have become with surrounding structures all matted together, forming an immovable mass. There is sometimes met with a form of circumscribed peritonitis which may be purulent or gonorrhœal, and this may have led to ovaritis. In such a case a painful and fluctuating tumor may be found low down in the pelvis. The tumor may be found encapsulated or to have burrowed into the lower segment of the pelvis. Rupture into the rectum or vagina, leaving an unhealed sinus through which a discharge quite exhausting to the patient, is not an uncommon occurrence that may be met with. When the attack is only subacute there may be considerable suffering from irritability of the bladder. Immobility of the uterus and agglutination of the pelvic and abdominal viscera give rise to extremely painful symptoms. When the attacks are of a grave character and there is a formation of pus, a hard and resisting mass of tumefaction with a sense of fluctuation may be detected. This is liable to give rise to displacement of the uterus. In cases of retained placenta, its degeneration may take place and this may be followed by the occurrence of a purulent indurated exudate in and around Douglas's cul-de-sac. In such cases the symptoms may assume a dangerous stage of depression. The duration of the disease is uncertain. In mild cases the disease may go on unrecognized as to its true import. In cases ending in recovery the duration often varies from three to fourteen days. In other cases the duration may extend from three to seven weeks, and may give rise to much acute suffering during the menstrual period. The

necessity of making a differential diagnosis becomes obvious. The diseases with which true pelvic peritonitis may be confounded are as follows:—inflammation of the cellular tissue, diseases affecting the tissues of the broad ligaments, the uterus and ovaries. In pelvic peritonitis the well-marked symptoms consist in excessive pain and great tenderness; relapses may occur. Pelvic cellulitis and pelvic peritonitis differ from each other and yet one may complicate the other. It is quite impossible at times to diferentiate between them. Cellulitis sometimes presents suppurative changes; peritonitis on the other hand may produce hardening of the whole pelvic roof. Pelvic cellulitis may undergo resolution, or it may terminate in suppuration, as before mentioned, or the pus may burrow into the surrounding tissue. Other diseases with which it may be confounded are fibroid tumors and hæmatocele. These can be excluded by attention to the peculiar symptoms characteristic of each particular disease. Ectopic pregnancy can be readily excluded by the history and symptoms of that class of cases. In the treatment of pelvic peritonitis, rest and freedom from all disturbances are absolutely necessary. The use of cathartics is not advisable. Complete control of the influences of pain should be effected. Opium in some of its various forms becomes the most important agent for accomplishing this. Opium controls not only pain but it also tends to lessen the severity of the inflammation; it overcomes in large measure the tendency to vomit, and it produces sleep. In cases, however, in which there may be a purulent collection its use is of less advantage. In other cases its employment is highly necessary. Local application of cold may moderate the pain, but many patients are unable to bear its use. There are cases in which hot applications afford marked relief. In cases in which tympanitis becomes troublesome a rectal tube passed up from the anal opening as high as can be

safely done will often afford considerable relief. Cardiac failure requires the use of some form of digitalis or the employment of strychnia, nitroglycerine and stimulants, as champagne and other alcoholic liquors. Milk, beef tea, fresh eggs taken in wine, are among the most useful nutrients. For the great advantage that can be derived by the use of large doses of opium in cases of peritonitis the writer referred to the well-known communication on the subject by the late Dr. Alonzo Clark.

Dr. W. Symington Brown remarked that the subject recalled his old experiences of 1845, when he was a student at the Lock Hospital in Glasgow, Scotland, and where he was so fortunate as to have charge as an assistant of many obstetric cases. He then improvised a speculum for vaginal examinations. He spoke of the ease with which a pelvic abscess pointing toward the vaginal wall could be incised by the use of Syme's lancet, especially could it be done when using a proper kind of speculum for aiding the operation. He spoke of the use of an aqueous solution of iodine instead of the tincture. Iodine in a solution of iodide of potassium will be found a most safe and beneficial application. Dr. Brown spoke of meeting a case in which a pelvic abscess was accidently ruptured into the vagina when he was attempting to make an examination of the part, and of the immediate relief this accident appeared to afford the patient. Dr. Brown expressed some doubts as regards the employment of large doses of opium in cases of impending abscess. He thought it preferable to open the abscess as soon as indications of purulent matter are distinctly present. Dr. Brown was not unaware that the opening of a pelvic abscess may sometimes be attended with danger. He therefore prefers the Syme abscess lancet, which is somewhat concave on its edge near its point, while near its point on the back it is slightly convex. ["Syme's abscess lancet" "a curved blade with a short point and a double cutting

edge."] For relieving pain Dr. Brown has made use of the following formula for external application: Chloroform ℥ i, Alcohol ℥ i, Tincture of Belladonna ʒ i and Tincture of Opium ℥ ii.

Dr. H. C. White, speaking from his own experience, thought that it was wise in cases of pelvic peritonitis to use laxatives for keeping the bowels in a solvent condition. He felt that he could then employ opium to a greater advantage; he said that he had not infrequently used opium externally. The use of turpentine and hot water or fomentations is another valuable means of relieving pain.

Dr. George W. Jones said that pelvic peritonitis may be divided into at least three classes, or rather it is dependent on three conditions. It may occur after delivery, it may result from diseases of the uterus, Fallopian tubes and the ovaries, or it may follow an attack of gonorrhea. Cases appear where the disease has undoubtedly resulted from general peritonitis or from septic infection. The presence of gonorrheal poison becomes a most prolific source of inflammation; a most innocent woman may become the subject to the disease without her suspecting the cause. The use of opium becomes an excellent method of treatment, but caution should be observed in its extensive employment, for opiates of whatever sort may deceive the attendant by merely relieving the pain without removing the underlying cause. Dr. Jones makes use of enemata for opening the bowels, because a want of free evacuations may become one of the leading factors that enhance the trouble. He had been accustomed to use enemas of oil and glycerine, also those in which turpentine had been added. Patients, he said, often express a great deal of comfort following their use. As soon as there are indications of the formation of pus an incision should if practicable be made for its removal. Dr. Jones made mention of the history of a case in which he made an abdominal incision for the discharge

of purulent exudation. This he did notwithstanding that some of the medical gentlemen who saw the case were opposed to the proceeding. He found the matter encapsulated and in a mass as large as a pint bowl. He encountered, however, much difficulty in washing out and in cleansing the abscess cavity. The patient recovered and has lived now already twelve years since the operation.

Dr. Augustus P. Clarke said that he had met with cases in which pelvic abscesses and peritonitis were dependent on diseases of the uterine adnexa. He made mention of a case in which repeated abscesses had formed above the vaginal fornix. In the first attack the case was seen by Dr. H. O. Marcy, who opened the abscess through the vaginal wall. The patient was relieved for a while, but after a year she came under Dr. Clarke's care. The speaker also succeeded in effecting an opening for the discharge of matter. The incision was made near the former point made for drainage. The patient, after two years, had a recurrence of the trouble which he again relieved by resort to a vaginal incision. Though the patient had been a great sufferer she never could be induced to submit to an abdominal incision for the radical removal of the abscess cavity. The disease was evidently connected with the uterine adnexa. Some time after her removal from this vicinity the speaker incidentally learned that she had had a recrudescence of the disease. The speaker said that he had known since his student days something of the method of treatment of general peritonitis by the use of large doses of opium as was advocated by the late Dr. Alonzo Clarke; that he had heard more or less criticism against the use of large doses of opium because it was regarded by some as a dangerous practice and seemingly to be a method of trifling with human life. He had nevertheless made free use of opiates in pelvic peritonitis after he had employed evacuants for the bowels, emollient fomentations and some of the various

forms of counter-irritation. As soon as indications are afforded of the formation of a purulent collection, measures must be instituted for its removal. Attendant pain, repeated chills, and sweating may be regarded as strong presumptive evidence of a purulent collection. He had been accustomed to follow the advice that he once received from that most careful observer, Dr. Morrill Wyman, of Cambridge, who from a long experience had found that in those cases in which pelvic or abdominal trouble was attended with severe constitutional symptoms, the occurrence of repeated chills of a marked type was to be regarded as a warning to be on the look-out for the development of a purulent formation, and that the employment of the knife would prove our best means for relief. In reference to the indications that pus was forming, Dr. Jones did not think that its occurrence was made manifest by the supervention of chills, as Dr. Clarke had mentioned, for he had had cases in which purulent collections had taken place without having evidence of the occurrence of a chill.

Dr. Clarke, in reply, remarked that he did not say that the forming of pus was always so announced, but when chills do occur in cases of pelvic peritonitis the surgeon should be on the watch, for he had known cases to be treated for mere intermittent fever when subsequent events showed that the chills were solely due to the occurrence of a purulent stage.

Dr. Horace C. White thought that if one would always be particular to keep a careful and an exact record of the pulse and temperature of a patient who was suffering from pelvic trouble, a pretty fair conclusion could be reached whether or not the disease was assuming a purulent stage.

Dr. Albert E. Miller said that he practically agreed with the views of the various speakers. He was accustomed to use opiates for overcoming any considerable pain; that he paid attention to the condition of the bowels. The use of

fomentations with turpentine was a favorite remedy with him. As soon as there is evidence of the forming of any considerable collection of pus, measures should be taken for effecting its discharge.

Dr. Carroll, in closing the discussion, remarked that many cases of pelvic peritonitis go on without the occurrence of purulent exudation or with the formation of but little or no pus. The chart records made up by the use of the thermometer may be deceiving, especially when there is an attack of salpingitis, though that condition may be attended with marked constitutional symptoms. Each case of pelvic peritonitis should therefore be judged by the presence of its own peculiar symptoms.

The meeting adjourned at six P.M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Meeting April 10, 1902, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

Dr. W. Symington Brown took occasion to exhibit and explain the advantage and uses of the "Syme" lancet for opening abscesses and for making other incisions, when the use of an anæsthetic was to be dispensed with. He remarked that as the blade was curved and much narrowed near the point it could be made to enter painful tissues more easily than if otherwise constructed; the cutting can be effected principally from within outward. Such incisions when made have long been recognized as being less painful than when made in an opposite direction. The point of the instrument is as narrow or as small as that of a needle. It can best be used by making a gentle but firm plunge into an abscess, and then by making it cut its way out as the speaker had before remarked. He had had at one time a little personal experience from its use upon himself, and he further remarked that the suffering was comparatively light.

Dr. Brown says that there may be some dangers attending its use, for without the exercise of considerable caution the blade may sometimes break, and such a mishap will of course necessitate a search for the broken point.

Dr. Norris exhibited a multiple bladed surgical pocket knife; the blades were small at the point and were convenient for carrying out purposes similar to those of which Dr. Brown had spoken. Dr. Norris had used in his practice the knife for the past thirty years and had found it a most serviceable form of instrument.

Dr. Carroll inquired whether members had had cases of recurrence of pelvic peritonitis following what seemed to be recovery from an attack of the disease.

Dr. Clarke, in answer to the inquiry, remarked that he had met with in his practice such cases. He referred to a case of which he had spoken in the March meeting. The patient had had an attack of pelvic peritonitis resulting in an abscess occurring in the vaginal fornix. From this she seemed to have recovered until a year or more later when she had a recurrence, and another recurrence some two years after an apparent recovery. Such cases usually have their origin in a pyosalpinx, the pus at varying intervals finding its way down into the Douglas's cul de sac. Hence arises the necessity of instituting at an early date the more radical measure for a complete removal of the seat of the purulent collection.

Dr. Carroll made mention of a case of a patient who had been treated for various supposed diseases. A surgeon at last having been called in, he cut down and found a sarcoma of the acetabulum.

Dr. Woods spoke of a case in which sarcoma had been found between the toes; the patient had been under treatment given by a chiropodist, or rather she had paid him a visit for such treatment; the disease finally extended to the glands of the thigh and to those of the groin. The patient had made use of corn plasters which may have been the cause of irritation.

Dr. Clarke spoke of a case of sarcoma which first appeared in the testicle of a man; the disease necessitated the removal of the testicle. The patient soon recovered from the effects of the operation and appeared well until about two years later, when a growth appeared in the abdomen; an abdominal incision revealed the fact that the development was connected with the omentum, and surrounding structures, and the parts were so deeply involved

that the mass could not be removed with any hope of saving the patient. After recovery from the effects of the operation the patient was for a few months much better; the pain in great measure had disappeared. The disease however returned, from which he succumbed. The patient attributed the first appearance of his disease to his wearing of unusually tight fitting trousers, which produced much irritation and pressure upon the testicle. The speaker thought that the sarcoma appearing in Dr. Woods's case may have been caused by irritation and pressure from the use of improper dressing of the foot. Sarcoma, much like carcinoma, starts undoubtedly from points where continued and repeated irritation has modified or lessened the nutrition of the part; and where such modification has thus been produced a local alteration in the development of the cells or structures composing the part involved is liable to occur. The speaker then referred to Dr. Tuttle's interesting paper given at the February meeting in which that writer made mention at some length of certain investigations on the lunatia heros. These observations had tended to establish the theory that the development of cancer reresults from a change in the environment of a cell or a group of cells, through which their normal growth (or rather through which their growth as is usually known, observed, or believed) becomes affected and through which their actual proliferation proceeds contrary to the manner in which the more general operations of the elements comprising them, take place.

Dr. Carroll reported a case of a uterine fibroid which subsequently took on a sarcomatous change; he ascribed the transmutation as due to the irritation which the morbid mass had produced and to a consequent change resulting undoubtedly in the normal cell element.

Dr. Norris expressed his conviction that long continued irritation, exerted especially on the pelvic structures, may be productive of sarcoma.

Dr. Miller's experience had led him to the same conclusion.

Dr. Carroll, in referring to sarcoma of the bone, spoke further of a case of a patient, a male of feeble or scrofulous constitution. The pain was in his right leg. The upper third of the right femur had to be removed. The bone was necrosed and presented in some places a soft caseous change, and in other places a dark spongy alteration; there were points in which gangrene had appeared. Now what was the cause? Had there been an injury to the blood vessels? Dr. Carroll had seen some eight or more different forms of sarcoma occurring in bone. The patient in the case spoken of had previously sustained an injury by the kick of a horse. He had been poorly nourished; his age was twenty-four years. There was no history of malignant disease in the patient's family.

Dr. Carroll spoke of a case of peritonitis seen in consultation with Dr. Jones. On tapping the patient one hundred and twenty-nine ounces of fluid were removed; later one hundred and twenty-five ounces of effusion were withdrawn. Subsequently, a very offensive discharge was passed from the bowels, containing a ring or cast of intestine. The patient after the discharge from the bowel became weak, the pulse was 120 per minute. The speaker thought that the condition was the result of an attack of acute hepatitis, as a quantity of bile had appeared in the discharge that came away spontaneously.

Adjourned 6 P.M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Meeting May 8, 1902, 4 P.M.

HELD AT THE

New Hospital of Dr. Albert H. Tuttle, Charles River Road Esplanade, Cambridge, Mass.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

A paper, entitled

Emergency Operations in Cases of Ruptured Extra-Uterine Pregnancy,

was read by Dr. John C. Irish. The writer stated in brief that he had had in his own practice two cases of extra-uterine pregnancy in which the sudden rupture of the sac presented symptoms of the greatest import. The first case occurred about two years ago and was that of the wife of a farmer. The patient's age was twenty-one years and her weight was two hundred pounds. Dr. Irish was called about one A.M. He then found the patient lying on the floor and in an insensible condition. It appears that she had missed one menstrual period; there was, he said, a distinct boggy mass to be felt in the right iliac fossa. The shock and prostration being so great Dr. Irish felt that the prospect of her recovery was decidedly unfavorable, and therefore to attempt an operation under such a condition and with surroundings so adverse as he there found them would be a most unwise procedure. After waiting some four hours or more, the patient, he observed, so far rallied under palliative treatment as to give indications that resort to an immediate surgical operation would be unnecessary. The second case happened in a woman in whom the extra-uterine pregnancy had advanced two months. The patient was seen with another physician, but the shock was so extreme it was considered that the condition of the patient

as in the other case was too critical for the adoption of radical surgical measures. Morphia and stimulants were freely resorted to. The reaction finally became so marked that operative treatment could be dispensed with. Dr. Irish stated that he was not unaware that the course that he pursued in the management of these two cases was different from the usual teaching, which enjoins that operative measures should at once be instituted for relief. Dr. Irish said that he had had no personal experience in operating in such cases when there was immediate danger, but he had operated at a later date in some twelve cases of extra-uterine pregnancy. The point, he said, he would like to make was that if each of those several women from their individual history had suffered from extreme shock, and had afterward rallied and lived for a considerable period before submitting to operative measures for final relief, the practice of waiting and employing milder measures as he had done in the two cases mentioned is not sometimes inadvisable to follow. The speaker further remarked that if all patients suffering from sudden shock or collapse superinduced by the accidents of extra-uterine fœtation would without receiving surgical treatment necessarily die, it would undoubtedly become the duty of the surgeon to operate without delay. A fatal issue from shock, through loss of blood, does not always occur; the loss of two or three ounces of blood may sometimes produce for a while as much shock seemingly as the escape of a much larger quantity really does.

Dr. A. L. Norris asked whether in either of those two cases mentioned there had been a uterine discharge. Dr. Norris said that he had had a case of tubal pregnancy terminating fatally; at the autopsy a large quantity of blood was found in the pelvic cavity. The shock had been great and there had been a bloody uterine discharge containing decidual shreds. In this case Dr. Norris said that he

waited some few hours with the hope that reaction would take place, but by so doing he felt at the time that he lost his patient. In another case of tubal pregnancy occurring in a woman aged twenty-one years, he did not wait but had her taken to a hospital, where an operation instituted proved successful. The occurrence of the rupture was accompanied with considerable collapse.

Dr. George W. Jones mentioned a case of extra-uterine pregnancy which occurred in his practice some three years ago. He was called in consultation. It had been thought that an abortion had taken place. The collapse came on suddenly, the heart sounds were feeble and respiration depressed; there had been a serous discharge from the vagina. Dr. Jones regarded the case as the result of rupture in extra-uterine pregnancy; he could feel a large mass of exudation low down in the right of the abdominal cavity. In considering all the circumstances he thought it best to wait; early next morning he found that the patient had a fairly good pulse, she also appeared bright, and so he proposed to operate at nine A.M. that day, but the patient objected. While Dr. Jones was at the house with the patient another collapse suddenly occurred, and the patient expired within a very short time. Examination showed that there was a large clot of blood but no fœtus had formed. Dr. Jones regarded the cause of death as due to shock from the occurrence of rupture in extra-uterine pregnancy. In closing, Dr. Jones remarked that in some of the cases of ectopic pregnancy patients may recover even after the occurrence of severe shock from rupture without their undergoing operative measures. In some of the cases he further said that there may be a great deal of useless surgical work undertaken.

Dr. A. E. Miller had had cases of ectopic pregnancy, in which rupture had not occurred.

Dr. Albert H. Tuttle said that no certain rule for all

cases should be established. The management of each case of ectopic pregnancy should be determined by the particular features that may be presented. Every case should be examined carefully. The operation, if done at all, should be resorted to to relieve suffering and to save life. He had operated a number of times; in some cases the operation became a desperate measure. He referred to the twelve cases in which Dr. Irish had operated. In some cases of rupture there will be hemorrhage and profound shock, in other instances such results do not occur. In almost any case something in the way of relief can be accomplished to stimulate the patient. The employment of salt solution may prove most helpful. In some cases the mass occurring as the result of hemorrhage may gradually enlarge and the hemorrhage continuing may lead to rapid death. In many cases, nevertheless, the choice of waiting may prove better than that of resorting to immediate operation. The quantity of blood lost, and not the character of the shock and other symptoms, may be the leading factors of danger.

Dr. A. P. Clarke, speaking from his own experience, felt that it was better, in some cases of shock from rupture and consequent hemorrhage, to wait, than to try to operate under adverse circumstances. Cases may occur in which a mere simple incision will save the life of a patient. In other cases, bad surroundings with poor light and with inexperienced help may forbid for awhile the undertaking of radical operative measures. Many if not most cases of pelvic hematocele may be the result of ectopic pregnancy. The shock in such cases is often alarming, and the quantity of blood extravasated is quite considerable, but in a number of instances occurring in his own practice patients have rallied and fully recovered from such a seemingly bad condition. In quite a few cases in which the remains of ectopic pregnancy had been met with the history showed that the shock at the time of the occurrence of rupture had been of a threatening import.

Dr. Marcy incidentally mentioned a case of ectopic pregnancy seen some three years since. The shock from rupture occurred at five P.M. and the patient succumbed an hour later. Another case he mentioned in which it had been thought that the patient had had a tumor, the mass was mostly on one side. The shock and hemorrhage were very great but the patient recovered.

A paper entitled "Laparotomies Incident upon Exceptional Conditions of the Appendix," was read by Dr. Henry O. Marcy.

The first case the reader reported was that of his former assistant whom the members all remember, the late Samuel N. Nelson, M.D. In 1885, Dr. Nelson had his first attack of acute appendicitis, distinct, severe, and an operation was considered. Recovery slow and never quite perfect. Dr. Nelson had frequently discussed with Dr. Marcy the advantages to be derived from an operation between the attacks. The operation was decided upon and performed in November of that year. Convalescence was rapid and uneventful with entire relief. Death occurred some years later from other causes.

Case 2.—October, 1887. A child two years old, previously healthy; attack acute. Previous consultant, a noted expert in nervous diseases, diagnosticated the case as one of acute tubercular meningitis. Temperature 104,° pulse 140 to 150 per minute. Examination of the abdomen showed a marked circumscribed swelling in the right iliac region, from a slight opening in which a purulent, dark colored, watery fluid was escaping. A free opening was made; upon examination, it was found that this pus-cavity communicated with the intestine and also with the bladder. He carefully freed the parts from adhesions and closed the opening in the fundus of the bladder by fine continuous double tendon suturing. There were two openings into the large intestine, one at the site of the appendix, readily

admitting the index finger. These parts were sutured in the same manner as was the bladder, and the wound was treated by drainage. Convalescence was rapid and uneventful; the patient became a healthy young woman of seventeen, never having had the slightest discomfort from impairment of the function of the organs involved.

Case 3.—August, 1887. Boy aged twelve years. Recovered easily after operation for appendicitis. Death occurred about six weeks later from other causes. Autopsy showed intestine involved, and only delicate bands of connective tissue marked the site where the operation was performed.

Case 4.—The patient a man. Consultation with Dr. James A. Dow of Cambridge. The subject was of good habits and had been previously well. The attack was accompanied with acute intestinal obstruction with stercoraceous vomiting. The pain was referred to the right side. *Operation.*—The site of the constriction was easily found. An appendix was discovered, measuring six inches in length, completely encircling the small intestine just above the iliocæcal valve; it was firmly adherent by old connective tissue bands, acutely injected, forming a plastic mass. The appendix itself was not perforated, and did not contain fecal concretions. There was no peritoneal infection. Separation was effected with some difficulty, and the appendix was removed. This freed the constriction so as to allow peristalsis to go on and the passage of the fecal contents and the gases to escape. Closure of the abdominal wound was made. The patient rallied imperfectly and died the following day from exhaustion.

Case 5.—Mr. M., age 22 years, entered his private hospital, October 1895, after recovery from the fourth acute attack of appendicitis. These attacks had been of moderate severity, but were distinct, seemingly to approach the danger line. Operation was done intercurrently. The ap-

pendix was free, somewhat enlarged, without stenosis. The muscosa was greatly thickened. A bristle about three quarters of an inch long was found in the distal extremity. This was evidently the cause of the suffering. Recovery was uneventful.

Case 6.—October, 1895, Mrs. H., aged 55 years, a multipara. She had an enormously fat and pendulous abdomen; her weight was upward of two hundred pounds. She was seen in consultation with Dr. John Couch of Somerville, Mass. The patient had been in bed for some weeks, on account of a circumscribed and tender swelling in the right iliac fossa. The diagnosis had then been undetermined. About a month later there was observed an opening just at the right of the umbilicus, discharging a peculiar looking material. On examination it was found to contain fig seeds. Upon inquiry the patient stated that she had eaten a fig the day previous. Further examination settled conclusively that this was a fistulous intestinal opening. An operation was at that time refused. She was seen for the third time some weeks later, when there were six irregular ragged openings all to the right of the median line, within a space of about five inches. Condition of extreme emaciation was very marked. The patient was then ready for operation. Upon section the different openings were found to enter into a common pocket located just over the fascia to the right of the right rectus muscle. Dr. Marcy next opened the abdominal wall in the healthy tissues above the fistula, and dissected it free from the intestine. There was an opening into the ilium, which admitted the tip of the finger. This was sutured; he found that the end of the appendix was firmly adherent to an abscess cavity into which it had opened. The appendix was six inches in length, it was greatly thickened and enlarged. This was removed. The strong fascia of the abdominal wall was sutured by layers. The infiltrated fat of the ab-

dominal wall proved the most doubtful factor in the operation, since the many sinuses had permeated it to such an extent that it necessitated the removal of an elliptical piece fifteen inches long and five inches in width. The wound healed without becoming infected, and the recovery though slow was satisfactory. The patient was fitted with a strong abdominal supporter which has still to be worn since, notwithstanding much care has to be exercised as to her diet. She has in large degree regained her flesh.

Case 7.—Mrs. M., aged thirty-six years, entered hospital Dec. 1892. In 1889 Dr. Marcy removed diseased ovaries and tubes which had caused total invalidism for the previous seven years; particularly so had she become by being bed-ridden. Patient made a slow but satisfactory convalescence, resuming her position as a prominent social leader. Early in autumn of 1892, she made a pleasure journey to the Azores. Upon her return trip she was seized with much suffering; she then entered his private hospital on account of severe and constant suffering in the left pelvic region; the patient declared that Dr. Marcy had failed in his operation by not removing the uterus with the adnexa. The cause of the symptoms at best were extremely doubtful, although there could be no question as to their severity. An exploratory laparotomy demonstrated that there was dislocation of the head of the colon with a very large inflamed appendix adherent to the left of the uterus in the cul-de-sac of Douglas. The adhesions were separated, the appendix removed, and the cæcum restored to its normal position. An interesting query arises as to a possible dislocation of the colon at the time of the first operation. There was no note of the condition or position of the appendix as it appeared at the first operation, and very likely no examination for such a purpose was made, because at that early date the rule to examine the appendix and gall-bladder in all cases of laparotomy had not been established

with him. The patient made complete recovery, and so far as now known has been free from abdominal suffering.

Remarks.—Although Dr. Marcy, as he said, was not aware of it at the time, he is now led to believe that the case of Dr. Nelson for operation between the attacks was the first on record. The credit for it, however, belongs quite as much to the inductive reasoning and purpose on the part of Dr. Nelson, as to Dr. Marcy himself, as he further said, since it will be remembered that such an operation at that early period was looked upon with a misgiving and doubt that the student of to-day can hardly realize. Although being one of the first of American surgeons to operate for appendicitis at that early date, he, Dr. Marcy, was nevertheless comparatively inexperienced, and besides, the whole subject in the minds of the general profession was hardly recognized.

Dr. W. S. Brown here took opportunity to say that he was always glad to hear the name of Dr. Samuel N. Nelson mentioned. He spoke of him as coming to the Soldiers' Home, in Chelsea, and of his being a most competent and faithful surgeon at that institution, and he spoke of the great loss the Home had sustained by his death.

Dr. Irish said that he was much interested in the subject of Dr. Marcy's paper, especially was he so in regard to operation for appendicitis. He himself had operated in at least four cases of appendicitis in which there had been intestinal obstruction ; he had operated for the removal of purulent collection from the abdominal cavity as early as 1884.

Dr. Tuttle, in his discussion of the subject of Dr. Marcy's paper, remarked that he had made it a general rule in his practice to remove the appendix in all cases in which he had resorted to abdominal section.

Dr. A. P. Clarke remarked that in many cases in which abdominal section is demanded the time limit is often a matter of vital importance. In such cases to prolong the time for search and removal of the appendix, when the

symptoms do not clearly indicate such a procedure would be, to say the least, quite unwise; the incision for the removal of the appendix, it should be remembered, is not often made in the median line as it is done in the majority of other cases of cœliotomy. He said that there may be other useless or functionless parts connected with the human organism, but removal of any one of these should not be undertaken unless the same becomes diseased and entails danger to the rest. Dr. Clarke said that he recalled the case of Dr. Nelson, as reported by Dr. Marcy as occurring in 1886, for he was present at the time of the operation and assisted in its performance.

Dr. Marcy, in closing the discussion, said that there were many points to which he might allude. He did not favor the use of the term "idiopathic peritonitis" and that in his early work of abdominal surgery he had discussed the subject with Dr. Morrill Wyman, and had expressed his objections to its use. He said that he did not feel that it was wise to remove the appendix, when an operation had been decided upon for other purposes, unless the appendix was found to be diseased, or it had previously given trouble to the patient. One reason in particular he mentioned was that in case a healthy appendix was removed, and matters afterward went wrong with the patient, the blame may be liable to be thrown back upon the operator. In any case of abdominal section the appendix should of course be removed, if it is found to be the seat of disease. He had operated some three hundred times for the removal of the appendix and he had found that the operation was not *per se* so dangerous as it had sometimes been represented. After the adjournment of the meeting, which was at six P.M., the members were received by the hostess, Mrs. Tuttle, and were welcomed to her table, where all partook of a most pleasant and refreshing repast.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Meeting December 11, 1902, 4 P.M.

HELD AT

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

Dr. Marcy exhibited an intra-ligamentous cyst which he had recently removed. There had been enlargement of the abdomen, especially on the right side, of about the size of that of a patient who was four months advanced in pregnancy. As the patient had of late been growing worse, Dr. Marcy decided to operate. On section of the abdomen, a large cyst was found imbedded in the right broad ligament; this was found to be quite difficult to remove, owing to the strong adhesions. The cyst, after it had been taken out and emptied of its fluid contents, presented a coarse, rough appearance, not unlike that of common tripe; it was flattened and irregular in shape, and was from three to five inches across its flattened surface. Dr. Marcy regarded this as a unique specimen, and one that he had rarely met with in his practice.

Dr. W. S. Brown then opened the discussion on "Rest as an Important Agent in Surgical Cases." There are certain lines along which physicians have always endeavored to work in carrying out surgical treatment. The importance of rest in treatment has a much wider significance than has usually been recognized. Dr. Brown, in illustrating his remarks, spoke of a certain famous teacher who once advised his students for an exercise to ascend a mountain; they were to ascend on one side and he on another. The students on reaching the summit were surprised to find that the teacher had been there some time before their arrival.

In explaining how this was done they were informed that the teacher in making his ascent moved slowly and rested somewhat at intervals before he became wearied, whereas it appears that the students in setting out hurried so much that they became overfatigued before making much progress; this necessitated delay and became the reason why they were outdone by their master. Dr. Brown referred to a remark made by a Scottish physician, who said to his friends on going out that if he should fall on the street, so as to be seriously injured, he should not be lifted up at once, but that they should first procure the necessary apparatus or appliances for his care so that the injured parts might be as little disturbed in transit as possible. Dr. Brown then referred to the history of the treatment of the three great personages of our time. First, King Edward VII was removed from his abode to a yacht and was thereby exposed to additional danger while still suffering from the effects of a grave pathological condition. President McKinley was removed, though it was but a short distance from the hospital where he had been operated upon, to a private house. This the speaker felt was not a wise measure of proceeding for the president's recovery. Dr. Brown said that the condition of President Roosevelt was such as not to warrant him in moving about as he did after receiving his injury by being thrown from the carriage. During the Civil War, the speaker said that there were not always favorable opportunities for insuring immediate rest for grave cases of injury. It was, however, always his custom to replace broken or injured parts as much as possible before resorting to removal of patients from the field or other theatre of action and allowing the soldiers to take transportation. He spoke in particular of one case in which he removed the broken fragments of the humerus without attempting at that time to amputate the arm as he might have done. He also spoke of the case of an officer who was se-

riously wounded, and of the extreme care he took before attempting to remove him from the scene of hostility. Dr. Brown referred to Hilton's famous work on "Rest and Pain," and of the great advantage the adoption of its wise teaching would insure. Dr. Brown expressed his approval of establishing places in which temporary treatment for cases could be successfully carried on. He was glad to see that all over Massachusetts small hospitals had been built. The practice of establishing hospitals of this class is especially favorable for lessening suffering, and is in striking contrast to that of being forced to transport patients suffering with most serious troubles to the larger hospitals which must necessarily be at greater distances apart.

Dr. Marcy in discussing the subject asked, Why should the patient suffering from a severe injury or a disease requiring surgical interference be kept in bed? The answer to this inquiry is obvious. The action of the heart can be more easily controlled; its pulsations will be found to be slower and more regular, the cellular changes of the whole organism will be less active. All experience in the treatment of such cases shows that the system becomes more generally saturated with moisture or with fluids of a perverted character. These have to be eliminated in order to establish a healthy reaction. This can be best accomplished by enjoining absolute rest, or by insisting on the least amount of disturbance to the patient that is possible. In regard to the effect on President McKinley, by his being removed from the temporary hospital after the operation, it could but have been very slight, for the distance to the place where he was subsequently treated was not great, besides the surroundings were better than where he at first was taken for operative measures. To show the injurious effects by the removal of a patient and the faulty methods of conveyance that are sometimes employed, Dr. Marcy instanced a case in which a patient who had been injured in the spine was

crowded, in order to furnish a bed, into a common hack and taken in that manner to a place for treatment. The bending or doubling of the patient into such a constrained position was of course anything but helpful to the patient's seat of injury.

Dr. A. E. Miller expressed his appreciation of what had been said on the subject, but felt that he could not add anything in particular for the elucidation of the discussion.

Dr. Burt spoke of the subject as being of much interest. Rest, he said, will prevent undue movements of the blood vessels. The circulation can be more easily controlled. By rest the pulse can be brought from a rapid to a slower movement. There are other factors to be brought in for consideration, which are often more important than rest. The bowels should be unloaded of their fæcal contents; measures should be taken to reduce a congested or oversurcharged spleen. The condition of the lungs should be attended to. Sometimes it is necessary to resort to massage; this often tends to free the system from unnecessary fluids, and to cause a more copious discharge of urine. Some exercise or movement of the body may nevertheless be beneficial by exerting a stimulating effect upon the secretions.

Dr. Albert L. Norris was an advocate of rest in important cases demanding surgical treatment. He thought that rest was a valuable means for relief of pain or for preventing its occurrence; this is especially so in that class of obstetrical cases in which the abdominal organs are seriously involved.

Dr. Jones, turning a little from the more particular point for discussion, remarked that all forms of life require rest for recuperation. We learn, he said, from an authority higher than human, that "God rested on the seventh day from all his works." Without our enjoining measures for necessary rest little can be accomplished in the treatment of the graver forms of surgical cases. He spoke of the

importance of the "rest cure," so called. Speaking again from his own personal experience, he said that in his early practice he took no rest or vacation. Nature calls for rest or a cessation at proper intervals from labor. The professional man above all needs rest, for such recreation makes him sharper, brighter and better fitted for doing good work.

Dr. Welch expressed his pleasure in being invited to be present, and of his interest in the discussion of the subject and his approval of what had been said in regard to rest as an aid to surgical measures.

Dr. A. P. Clarke remarked that while he regarded rest as a potent factor in the treatment of abdominal lesions and injuries requiring surgical interference, his experience nevertheless justified him in saying that there were many cases in which exercise and passive movement of the patient sometimes became most beneficial. He recalled his experience in the treatment of the more serious fractures as of those of the tibia and femur, that the use of plaster-of-paris dressings firmly applied enabled the patient to be up and about at an early date, instead of continuing for a great length of time in the horizontal position; this, he said, Dr. Marcy would readily assent to as he himself had long since recognized this advantage in the treatment of such cases. One case in particular he mentioned, in which there had been fracture of the tibia and fibula, near the ankle, of a woman of a heavy build and past the middle age. The patient though treated by the application of immovable dressing was not inclined to avail herself of the advantages that would accrue to her general condition and muscular power by leaving her bed as she could have done at an early date. On the forty-fifth day after her injury, though she had complained of no particular suffering, but had had her usual diet, she died very suddenly, to the surprise of all. Autopsy showed that the fragments of bone were well coapted, and that union had become quite firm. No trace of an embolus could be found. The heart itself had, how-

ever, undergone softening and other degenerative changes, which had undoubtedly been superinduced or hastened by want of exercise during the long time she was assuming the recumbent position. Speaking from his own military experience during the Civil War, he said that it often became exceedingly irksome for a soldier who had been wounded after leading an active life to submit to enforced rest. He mentioned a general's orderly who resumed his duties next day after sustaining fracture of the clavicle and the acromion process. The mere wearing of the usual dressing for those injured parts and the guiding of his horse by the hand on the other side were practically his only inconvenience. Speaking further from his army experience, he said, that during the expedition of the First Cavalry Division, of which he was then surgeon-in-chief during the winter of 1863–4, from Winchester through the mountainous regions of the Blue Ridge to Lynchburg and Gordonsville, Va., many of the seriously wounded, some forty in number, had to be transported in ambulances in following the movements of the cavalry in its circuitous route over that rocky, frozen, and precipitous region, for more than three weeks resting only at night or at such other times as were necessary for the care of the troops for action. Strange to say that many of the wounded who had sustained amputation, resection of a limb, or were under treatment for other grave injuries, besides having to endure the effects of the severe cold weather, were kept in good spirits, and were observed to have made surprising progress toward recovery. Again, he said, that during the battle of Mount Jackson in Virginia, November 22, 1864, the Second Brigade, of which he was then surgeon-in-chief, established a hospital in the vicinity, and were making preparations to remain for the night, but owing to the failure of General Averell's Cavalry to arrive in time for support, orders were given to withdraw our lines and to resort to a retrograde movement. All the wounded who could not mount a horse

or travel on foot were to be left there to the tender mercies of the enemy. Out of the twenty-eight wounded soldiers who were in that cavalry hospital, and several of whom had undergone amputation or other great operation for injuries received, only one consented to remain. The wound of this one was through the abdomen, implicating the fundus of the bladder. Even he, before the cavalry left, was transported upward of half a mile on an army blanket to a house of a Confederate. All the wounded, though subjected to the severe ordeal of an all night's travel and exposure, did well and made timely recovery. Some ten days later on our return to our former scene of action we found the soldier who had sustained the abdominal injury had made fair progress toward recovery.

Dr. Woods spoke briefly. He said the subject can be approached from different points of view. He was inclined to favor the position taken by Dr. Brown in his opening remarks, that rest as an aid in the treatment of surgical cases is often of great importance. The view taken by Dr. Jones, he said, he readily appreciated, but he was disposed nevertheless to adopt, in considerable measure, the conclusions reached by Dr. Clarke. Exercise, to a certain extent, facilitates a return of the organs to healthy action. He spoke of a little boy who was put to bed for a cure without medicine. A change of environment may sometimes be of service. He spoke of a case of a woman who had been thought to be seriously ill. Several physicians had from time to time been called upon for giving her treatment without their being able to render much relief. In some such cases exercise and change of scene may be most influential in stimulating the organs to perform their normal functions.

The meeting adjourned at 6 P.M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Annual Meeting, January 8, 1903, 4 P.M.

held at the

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

After the usual preliminary business, the president, Dr. Woods, proceeded to deliver his annual address. The speaker, in choosing a theme for consideration, departed somewhat from the usual custom of his predecessors, for he took for his subject, "*Some Considerations on the Life and Duties of the General Practitioner.*" The work of the general practitioner can, he thought, be best considered under three heads:

I. His duty to his patients and to the general public.
II. His duty to other practitioners.
III. His duty to himself.

The obligation which a physician owes to the community in general cannot in these times be over-estimated, especially so, can it be when our faith in the curative power of drugs is being shaken, and we are coming more and more to realize how large a factor in the prevention and cure of disease is the influence of food, sanitation, hygiene, and the judicious combination of exercise and rest. He referred to the fact that the earliest practice of the healing art was largely confined to the alchemists and astrologers, also to the priests and clergy. In process of time medical science gained a more permanent foothold and it became necessary that a separate body of men should be trained for the more particular work of caring for the sick, and so the practice of medicine and the teachings in theology were divorced. For a long time after the emancipation of medicine from

the prevailing church service, the carrying on of the art was little better than that of quackery or the pretensions of the empirics. In considering the early medical practice, one is enabled to distinguish between what was charlatanism and what may now be regarded as an approach to legitimate medical practice at that early period. The absurdities into which the ablest minds were led by the exercise of speculative empiricism appears so glaring that nothing could be brought forward which would transcend such vagaries. It should be remembered, however, that in the time to which reference has been made the method of close scientific observation had not obtained recognition, and that the prevalent idea of the possession of learning was embodied only in the thought of cultivating the spirit of philosophical speculation. By the gradual advance in general matters, a clearer insight into the nature and development of disease led to greater directness of methods of overcoming morbid processes. The achievements in modern physiology have undoubtedly been more productive of useful results than have those of pathology, but even more perhaps has been learned by noting the processes of spontaneous recovery as they have occurred in animals as well as in man. How different is this view from the conception that disease is an entity to be starved and, as it were, to be strangled by the exhibition of violent remedies, or be made to escape by excessive discharges of serum or of blood. Nature, it is true, should not always be left to her unaided powers to effect relief. Among the most important curative agencies which may be mentioned is rest, sleep, and change of scene, exercise and pursuit. Sleep alone, that profound sleep to which poets have likened death, can often prove the restorer of the worn down nervous centres. Prolonged rest in bed is not unfrequently the first need, and the proper use made of this means toward the restoration to health forms the essential part of the "Weir Mitchell Rest Cure." Of late the open air rest cure

for tuberculosis has in some measure replaced the method of active exercise which was once in general use in sanitaria.

The fact should not be lost sight of that the practice of prescribing rest as a curative means may be carried too far, as an important result there may occur a greatly impaired nutrition of the organism, atrophy of some of the more important parts and a general deterioration of the cerebral or other physical powers. The speaker next made a plea for the encouragement of physical culture so-called. The vice of the age, he said, was in relying too much on the agency of means for stimulation; this may be some form not always in that of eating or drinking to excess. It may sometimes be indulged in through social dissipation, ambitious efforts, the spirit of competition, excitement of the imagination, and through a thousand ways by which nervous force becomes consumed much too fast for the recuperative powers of the organism. Muscular effort, the speaker held, is a cure for nervous irritation and overstrain. Most excellent results have been obtained from tennis, golf, bicycle, horse-back exercise, from walking and from any form of continued or prolonged muscular exercise, which may be taken in open air. Woman has never perhaps been so much given to athletics as at present. Young women are developing a greater stature and attaining to a better weight, thus showing a more healthy complexion and a firmer balance in the function of the nervous energy, than were observed before this fondness for physical culture had invaded to such an extent their social environment. So far as regards the duty we owe to our fellow practitioners, it can, said the speaker, be briefly summed up as stated in the Golden Rule. Petty jealousies, however, are liable to warp our vision and to make it difficult to observe that rule set for our guidance; if we maintain, nevertheless, a broad outlook on the pursuits of life and be firm in keeping toward the rule for action, we shall not be liable to go far astray.

In speaking of the duties that we owe to ourselves, the speaker said, that we all know that the practice of medicine is not altogether a life of luxury or of ease. The physician finds that he has to pass through many varied experiences. Do we ever consider, said the speaker, that while the average business man has fifty-two Sundays and also seven if not eight weeks (one-sixth of the year) in which he may be entirely free from the great concerns of life, to say nothing of the reasonable certainty he has of having good nights' rest, while the physician, on the other hand, has scarcely a single hour out of the whole twenty-four of the day in which he may be really free from interruption, on account of the liability of calls for immediate important professional service. Speaking further upon the more important responsibilities of the professional men, he said, that there was nothing like enthusiasm that could make such service endurable. The physician should not only love his profession, but should also so grow in the development of its requirements that he will become oblivious to all the difficulties that might otherwise seem to beset his path in the furtherance of his calling. The tendency of many physicians is toward becoming so lapsed into the routine of their service as to neglect other means for mental cultivation. No one without having some kind of habitual mental recreation will be strong enough to bear with impunity the strain incident to an active professional life. It is essential for a busy physician to indulge in some sort of a diversion. It matters but little whether it be in a branch of natural science, in a department of general literature, or in something entirely different from either, so long as it is sufficiently absorbing as to lead him from time to time to the consideration of themes outside of his strictly professional work. The important purpose to be kept in view is to have an intellectual hobby (as the speaker termed the exercise) of some kind so as to guard against the danger, while being devoted to

professional work, of becoming narrow in thought or mental apprehension. The speaker next emphasized the importance of cultivating while in professional work a spirit of contentment as a means of obtaining greater power for service. The physician, it should be further remembered, is not infrequently consulted about matters which are not strictly medical. It not uncommonly becomes therefore his privilege to minister to the wounded spirit as well as to the weakened body. In general practice the physician has exceptional opportunities of meeting much that is interesting and instructive, much that will keep his sympathies warm and his spirit at least free from danger of suffering from the effects of discontent.

The speaker brought his address to a close by referring to the beautiful picture that attracted much public attention a few years since, and which fitly represented the good physician in his anxious concern for the restoration to health of a little patient and in his own desire to extend his sympathies to the father or the family of a patient passing through such a trying ordeal. The following lines were added, which bespeak the sentiment impressed:

> "What does it tell us; what to thee,
> The noblest task on earth was given,
> The brightest service that we see
> Conferred on mortal under heaven,
> To heal the sick, to lighten pain,
> Gently to cool the heated brow
> And like an angel bring again
> Hope to the hopeless, such art thou."

The meeting adjourned at 6 P.M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Meeting March 12, 1903, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

Dr. Marcy exhibited a large number of gall-stones which he had recently removed from the gall-bladder of a patient aged sixty-five years. The patient had suffered for a considerable period from attacks of pain, jaundice, and other distressing symptoms; she had been under the treatment of Dr. William H. Clancy of Cambridge, who had sent the patient to him for surgical attendance. The gall-stones were odd shaped and had mingled with them bits of calcareous matter of various sizes, resembling spiculæ of bone. The contents were confined to the gall-cyst that had become greatly distended with biliary products. The patient after the operation made a comparatively rapid recovery. Dr. Marcy next showed the ovaries which had undergone degenerative changes and which he had recently removed from quite a young patient who had been a great sufferer for a considerable period. The altered mass was found in Douglas's cul-de-sac. The patient had been under the treatment of several physicians before the correct diagnosis had been reached. Dr. Marcy next read from notes that he had made of cases in which he had operated. He remarked, while speaking of a plastic operation for the relief of vesico-vaginal fistula, that the secret of success lies in the matter of making a free dissection into the surrounding tissues. He mentioned a case in which he had separated the bladder tissue from that of the vagina and had overcome all

abnormal adhesions; this practice tends to keep the part in which artificial union has been attempted at rest, so that primary union may go on uninterrupted. The speaker thought that the practice of so doing was peculiar to himself.

Dr. Jones, in discussing this phase in the matter of operating for the cure of vesico-vaginal fistula, remarked that he had often adopted a similar course and that the method of so doing had occurred to him as it had undoubtedly to Dr. Marcy. Dr. Jones said that the separation of adhesions was most essential and that the failure to obtain relief, as Dr. Marcy had said, has been largely due to lack of attention to this proceeding.

Dr. W. S. Brown, in speaking of operative measures for the cure of vesico-vaginal fistulæ, said that it was a subject in which he had long been interested; that the real inventor of successful methods was the late Dr. Marion Sims. Dr. Brown made mention of a case of a woman who years ago had undergone operative attempts by an eminent surgeon but was never relieved until he himself had sent her to Dr. Sims, who was successful in curing her by a single operation. Dr. Sims, he said, as was well known, always made use of silver wire for the suturing.

Dr. Marcy remarked that he had not for a considerable period of time past met with many cases of such fistulæ; he was inclined to attribute the present fewness of such cases as due to the great advance made in the obsteteric art as now carried out to prevent mishaps of such a character. Speaking of the use of wire sutures for such cases, he said a danger in their use was in the liability of their being sometimes overlooked; that he had in the past been called in, long after union had taken place, to remove some suture that had been overlooked at the time of their final removal, the patient in one case remarking that she had long been much annoyed by the use of such pricking devices in order

to keep her bladder together. Dr. Marcy next reported a case of disease of the gall-bladder complicated with appendicitis. There had been emaciation, and frequent attacks of pain and jaundice. The pain and other symptoms being sometimes so low down toward the pelvis that uterine complication had been suspected. An operation for the removal of gall-stones and also for inflamed appendix often afforded complete relief for such attributed conditions of uterine affection.

Dr. Jones, in discussing the case, said that he had had, not long since, a case in which disease of the appendix cæci and of the gall-bladder coexisted. He planned his incision so as to remove, if necessary, the appendix, and to open the gall-bladder for the removal of calculi. He had in this case, as Dr. Marcy had in his own, found that there was no uterine trouble, but that there was tenderness and swelling over the site of the gall-bladder. Dr. Jones found numerous adhesions quite strong and fibrous about the appendix. These he dissected up; the appendix of fully four inches in length was removed. The gall-cyst was incised and the calculi and products of inflammation were removed. The patient made a good recovery. Since then she had become pregnant and given birth to a child.

Dr. Augustus P. Clarke recalled the case and of assisting Dr. Jones at the time in the operation spoken of.

Dr. Marcy remarked that in addition to the adhesions about the gall-bladder in his case there was found a little band of adventitious tissue lying across the common duct, that had undoubtedly added much to the sufferings of his patient. Dr. Marcy reported a case of Mrs. M., aged sixty-two years. She had enlargement of the uterus, which had been the source of considerable hemorrhage and had given her much trouble. The uterus had been curetted, but this gave only temporary relief. On September 11th, he opened into a small fibroid, which was in the left side of

the fundus uteri; he then found that the whole uterine wall was involved. The disease proved to be a papillomatous sarcoma. This necessitated the removal of the entire uterus including the appendages. In answer to an inquiry, Dr. Marcy remarked that it was always best to remove, in sarcomatous disease of the uterus, the adnexa as well as the uterus itself. Dr. Marcy made mention of a case of a woman, aged thirty-five years, who had suffered from an abortion; she had lost upward of thirty-two pounds in weight within two weeks. Careful examination revealed the existence of a pus-sac of the Fallopian tube, which necessitated its removal. There had been no indication of gonorrheal disease as a cause. He next reported a case of sarcoma of the tibia in a woman aged twenty-seven years. This appeared to result from an injury of the bones about the ankle. There was noticed an unusually marked difference between the two maleoli of that side. The disease continued to advance so far as to require amputation of the limb, which he performed at the lower third of the thigh.

Dr. Jones asked why amputation was not made at the knee instead of at the lower third of the thigh.

Dr. Marcy replied that the amputation was done there for the reason of greater convenience in wearing an artificial leg.

Dr. Jones remarked that recent improvements in the construction of artificial limbs appeared to insure now quite as much comfort in wearing one in a case in which amputation had been done at the knee as it does where it had been made at the lower third of the femur.

Dr. Marcy made mention of a case of a woman seen by him the 15th of October last. She was anæmic and had suffered much from uterine hemorrhage. The uterus was found on careful examination to be much enlarged, containing a sloughing fibroid tumor of considerable dimensions. This he removed, but the patient died ten days later from

inter-current pneumonia. He spoke of another case of a woman aged forty-three years, who had suffered from paralysis of the left arm and leg, evidently due to the presence of a uterine fibroid, for on his removing of the same she was relieved of the paralysis. The complication resulted without doubt as a reflex symptom superinduced either from disturbance of the vasometer centres or of the general nervous system. In speaking of operating for the removal of the appendix cæci, he said that he formerly was accustomed to dissect away the peritoneal tissue, then to incise and suture so as to close in all incised serous tissue, but of late he had invested that tissue after a mere incision, then using the purse-string method for closing back the exposed surface. This expedient has given good results. He next spoke of another case of gall-bladder surgery, in which the cyst had become enormously enlarged from contained bile and calculi. He spoke of operating November fifteenth in a case of a beardless man, aged twenty-four years, for a supposed undescended testicle. An incision showed that there was no testicle in the peritoneal pouch, and nothing like a spermatic cord. There was, however, a small mass of omentum in the pouch. The penis was infantile in appearance. He made mention of operating November twenty-ninth for the removal of an intraligamentous cyst of the broad ligament, which had assumed a suppurative condition. For ten days drainage was maintained for the discharge of the purulent matter. The patient finally made complete recovery. Dr. Marcy spoke of operating in a case that had been regarded as the result of ectopic pregnancy. The swelling proved to be the result of a mere hemorrhage into Douglas's cul-de-sac, from the occurrence of rupture of veins that had developed there in a mass of preternatural size. Dr. Marcy, who had been appointed at a previous meeting (November 1902) the committee to bring in a list of names of members who should be the officers and

committees for the current year, reported that all the members who had served for the past year in that capacity should be re-elected. The same were afterward declared by the President as duly elected for the current year. The following are the names: —

For President, Dr. J. Henry Woods.
For Vice-President, Dr. Albert H. Tuttle.
For Secretary, Dr. Augustus P. Clarke.
For Treasurer, Dr. Francis E. Carroll.

For Committee on Membership: —

Dr. Henry O. Marcy.
Dr. Albert L. Norris.
Dr. Horace C. White.

For Committee on Pathological Specimens: —

Dr. Henry O. Marcy.
Dr. George W. Jones.
Dr. Vesta D. Miller.

For Auditor, Dr. Jesse F. Frisbie.

The meeting adjourned at six P. M.

Augustus P. Clarke, M.D.
Secretary.

Meeting May 14, 1903, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

Dr. George W. Jones read a paper, entitled "Operation for Strangulated Femoral Hernia."

The author, in the course of his remarks, referred to the difficulties that are sometimes encountered in arriving at the correct diagnosis and the means of treatment of such cases. If reduction cannot be reasonably effected, and the parts are suspected to have undergone pathological changes, extirpation should of course be resorted to. In the removal of such affected parts the section becomes an attempt at an abdominal operation. In cases in which the condition has been of long standing the hernial sac will usually be found to have undergone much alteration. In almost any case in which a hernial sac is low down in the labium majus, complications in an operation for relief are liable to be met with; and although exercising the greatest care in operating, the hernial sac may be opened before the surgeon becomes aware of what has happened. In operating after the constriction has been overcome the mass may be stitched to the walls of the incised parts, or the hernia may be dropped back into the abdomen, as occurs in cases of mere reduction by taxis. Dr. Jones deviated a little from the general direction, by first dissecting out the sac. He would first free the constriction and avoid wounding the sac before returning it to the abdomen. The case he mentioned in par-

ticular included the following record. The patient was seen March 30; her age was 67 years. The condition of the case appeared to be such as not usually seen. The hernia had evidently been strangulated for at least two days. The patient had suffered from general constipation of the bowels. The history of the case showed that the patient had worn a truss for the past twenty-six years. Taxis failed to effect reduction. The right ovary could not be found in its normal situation, but appeared, as far as could be judged, in the hernial sac. On March 31, operation for relief was undertaken. After making an incision the tissues all about were freed from constriction. Scarcely any fluid was found in the canal. Gentle pressure made after nicking portions of Gimbernat's ligament and parts in the vicinity offered ready means of drawing out the mass so that it could be sewed off; the pedicle after receiving proper treatment was returned to the abdominal cavity. In the neighborhood of the hernia mass was found a small abscess that had to be attended to. The patient in due time rallied well, and made good recovery. Dr. Jones showed the specimen to the Society. He had received a report from Dr. Whitney, pathologist at Harvard, in which it was stated that no ovarian tissue could be discovered in the mass as removed, which Dr. Jones had submitted to him for examination and report. The outer portion gave evidence of the hernial pouch; the inner portions appeared at first glance like ovarian tissue, but were really regarded as omental structure.

Dr. Lockhart said that he had become much interested in the case; he had seen about a week before a strangulated hernia occurring in a child. In the case mentioned Dr. Lockhart had in operating sewed off a part of the sac. He asked the reader what he usually does with the sac in such cases. Dr. Jones in his reply said that he generally leaves the sac, or rather he seldom or never removes it in congenital cases in young subjects.

Dr. Carroll thought the report of the case by the reader was of great interest. He inquired in regard to employment and advantage of silver-wire sutures in such cases. Dr. Jones said that he used only tendon sutures in this case. He said further that omentum is rarely found in cases of femoral hernia; he thought it was always better to have the omentum removed than it was to leave it, especially if it had been strangulated. In making his dissection for freeing the constriction, he could feel the hard ridges of the femoral vessels as those about the artery, the vein, or the nerve. Injury to these of course had to be avoided. He endeavored to make his wound as dry as possible, though there was a tendency to capillary hemorrhage. This may have been due to over-manipulation in attempts to reduce in first place by taxis. The parts were found to have become very sensitive. The reader further remarked, in regard to the use of silver-wire sutures, that some of the best operators do not use them at all; other surgeons, however, resort to their use, as does Dr. Howard Kelly, at times. The reader much prefers well prepared tendon material for sutures. It was in one case only in which failure happened, and this mishap was evidently due to the material by some accident having become infected.

Dr. Clarke thought that the reader had presented strong evidence in support of his having operated on a case of femoral hernia of the ovary, and it would undoubtedly have passed as such, but for his precaution taken for accuracy by his submitting the specimen for report to Dr. Whitney, the pathologist, as has been mentioned. Undoubtedly specimens from some of the cases of supposed strangulated femoral hernia of the ovary heretofore operated on and published as such were not subjected to the crucial test, as was done in the case as presented by the reader.

Dr. Lockhart reported a case of a woman who had always regarded herself as being well until at a time when

she thought that she had become pregnant; she had missed two menstrual periods. She soon after was attended by a physician, who diagnosticated her present suffering as the result, as he thought, of an abortion. More careful examination proved that the pelvic cavity contained much blood. In operating he removed the appendix vermiformis, which was adherent or involved in a morbid mass on the right side. He showed the specimen, which contained a mass of clotted blood; the left tube and ovary had undergone much torsion. The right tube showed pathological changes in connection with a recent hematoma and disease of the vermiform appendix.

Meeting adjourned at 6 P.M.

AUGUSTUS P. CLARKE, M.D.

Secretary.

Meeting November 12, 1903, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

Dr. Marcy opened the discussion on the subject, entitled, "*Surgery of the Gall-bladder.*" He referred to some of his early experiences he had had in the treatment of patients who had been sufferers from the effects of calculi occurring in the biliary passages. He mentioned in particular the case of the late Dr. John R. Palmer, of Cambridge, professor in chemistry at the New England Female College of Boston, and how that distinguished physician had from time to time suffered from the presence of large gall-stones, and how the patient had hoped the time would come when such suffering could be relieved by resort to safe surgical measures. The speaker showed to the Society the calculus that he removed from that patient after his death. The history of other cases of gall-stones that had been the cause of much suffering he touched upon, but these were before the time in which surgery of the gall-bladder was deemed a procedure safe to undertake. He referred to the fact that cholecystotomy had practically its origin in this country; he made mention of the operation as performed by Bobbs in 1867, and of the greater perfection given to it by Marion Sims some eleven years later. He reverted to some extent to the subsequent experiences that Lawson Tait had had in cutting over the tumor and suturing the gall-bladder to the abdominal wound before emptying the cyst of its abnormal contents. Tait, he said, had operated as early as 1881, in some fifty-four cases of biliary calculi,

meeting with only two failures. From that time forward the operation could be said to have been regarded as a properly established surgical procedure. Dr. Marcy made mention again of a case of a woman who had come from a distance to consult him. She was evidently suffering at the time from obstruction caused by biliary calculi. The late Dr. Henry I. Bowditch, who was called in consultation in the case with him, did not hesitate to advise resort to operative measures, as the patient, the consultant felt, must soon succumb if relief was not afforded. Another consultant, who was called in, was opposed to surgical measures because, as he thought, he had traced a history of cancerous taint in the patient's family. Another distinguished physician as consultant was at that time uncompromisingly opposed to the adoption of surgical measures. Though the members of the family were possessed of good sense they were nevertheless forced to conclude that they had better trust to the kind care of God in Heaven than to the experiences of men whom they could consult. Dr. Marcy had soon, however, opportunity to recover at the autopsy the calculi which he no doubt could, when consulted by the patient, have successfully removed. From experiences such as these Dr. Marcy felt that he owed a duty to himself that should be so discharged as to afford the greatest relief to others, so he has devoted some of his best energies to the furtherance of the advantages of this kind of work. One of his first cases of operative measures in this line of proceeding was that of a physician. The suffering had been of considerable duration, but the outcome was a successful result. In this connection Dr. Marcy said two questions arise for consideration, — first, what is the cause of a gallstone; and, next, when shall an operation be undertaken. In answer to the first question, it may be said without going into the consideration of the various features of causation, that a gall-stone or biliary

calculus results from a concretion formed from obstruction to the flow of bile. In one case in which he had operated he found the contents as dark as common gunpowder; this may have been due to the alteration of the bile taking place on the mucous surfaces of the biliary passages.

The operation is necessitated in cases in which gall-stones are lodged in the common duct or are in the gall-bladder, and have become the cause of frequent severe attacks of biliary colic. The next question to be considered is how the presence of biliary calculi are to be diagnosticated. Jaundice used to be regarded as a pathognomonic symptom. The passage of gall-stones to the duodenum is often accompanied by severe attacks of vomiting and pain. In answer to the question where do biliary calculi for the most part develop, he said that their seat, if not their origin, may be found in the various passages of the biliary system. He mentioned in particular the occurring of a gall-stone that had at intervals, from the gall-cyst to the common duct, a ball valve movement or a movement from the common duct to a pocket or diverticulum lower down, in which it may have become lodged and thus offered an increased obstacle to removal. Such cases he had not unfrequently met with. A diagram of such an abnormal situation he showed upon the blackboard. Although he had been largely successful in the management of his cases, he nevertheless spoke of the dangers incident to the resort to procedures for removal. It was only within a few days that he removed the gall-bladder in a case of a woman who had submitted to some eight different major operations. The patient came to him at first about a year ago, when he opened the gall-bladder and attached it to the peritoneal surfaces. Ever since that time the patient has had more or less discharge; the attending physician, after the first operation, cut down to give greater exit to the exudation, but there being no perceptible improvement, the patient

was brought back to Dr. Marcy for further operative measures. He now found that there was a pocket which had been formed; this gave rise to the outflow. There was also a sinus that led from the gall-passages to the source of discharge occasioned by the presence there of a calculus.

Another case he referred to had been sent to him by a physician from another state. In this case a little gall-stone was found closely wedged low down in the common duct. Another case was referred to him for treatment by an obstetrician; in this case was found a dilated gall-cyst, which could easily be brought upward, but was found to contain no concretions. The operation was followed by a free discharge of bile; under the influences of rest and careful attention the patient appeared to improve. She subsequently returned, having become much emaciated. Further operative measures showed that the parts were inclined to bleed profusely, and that this condition was difficult to overcome. The wound was carefully packed, but the case ended fatally. The autopsy revealed that there was a biliary calculus that had escaped from the common duct to one side.

Dr. Marcy remarked that Dr. McBurney operates in some classes of cases by approaching from below; such a method of operating is however liable to be attended by many complications and exposure to much danger.

Dr. Brown, in discussing the subject of biliary calculi, confined his remarks mostly to the uses of olive oil; he said that some surgeons, and notably one he could mention, appeared to be non-committal as to the action of such oil. He had himself used the oil, particularly in such cases when they were attended by much constipation.

Dr. Jones recognized the fact that surgery on the biliary tissues is very difficult work, and not such as should be attempted by a mere novice. He had been much interested in listening to the report of the results of Dr. Marcy's

extended experience in work of that direction. He spoke of the successful outcome of a case of a woman on whom he had operated. This case of biliary obstruction was complicated with a diseased appendix vermiformis, which he removed at the time of the operation for the gall-stones. So far as the use of olive oil could be of benefit, he would only speak from his own experience. He had used such oil in connection with chloroform and sulphuric ether; he used this combination three times a day, and in some instances he had found its action as he felt to have been of benefit. The theory of its salutary action is based upon the well known fact that bile emulsifies fats, and that chloroform and ether may greatly assist or intensify this action. Some physicians have attempted to inject chloroform into the common duct, and reported that good results have followed. Dr. Jones made mention of a case in which he had operated and had removed upward of sixty gall-stones of various sizes. The patient recovered. Many patients suffer more or less from the effects of gall-stones, and yet the condition goes on unrecognized. And it is only at the autopsy that the true underlying causes of their suffering are discovered. In cases in which patients have become emaciated, detection of the presence of biliary calculi may not be difficult of accomplishing. It is in such cases, and especially so when the emaciation has not unduly taken place, that resort to operative measures may be most successful. He showed a specimen of gall-stones found at an autopsy. This was from the case of a patient in which he had operated for cancer of the breast; he had removed very thoroughly the affected glands of the axilla. The patient after the lapse of some months began to have dyspeptic trouble; she had pain below the site of the breast that he had removed. He afterward thought that he felt an unusual hardness over the gall-bladder. Some two weeks later the patient had vomiting and gradually became entirely

jaundiced. She next vomited black bile. The diagnosis was gall-stones, though there were strong indications of a recrudescence of scirrhus. The patient afterward had two recurrences of hemorrhage. The disease proved to be malignant, and that it had involved almost every part of the abdominal cavity. Two gall-stones were found, one was located in the common duct. This was surrounded by a hard mass. The condition found at the autopsy accounted for the hæmatemesis from which the patient had suffered. Dr. Jones exhibited specimens of calculi to the Society as before remarked.

Dr. Norris recognized the difficulties that may be encountered in operating for the removal of gall-stones. He made mention of a case of a patient who had had recurring attacks of biliary colic. A prominent surgeon, being called in, cut down over the site of the gall-bladder, but was then unable to find any calculi. Next day five gall-stones were discharged from the wound, and within a period of six weeks upward of sixty gall-stones passed out through the open wound.

Dr. Wing, on being called upon for remarks, said that in the discussion of the subject many interrogation points present themselves along the line, and that one of these has to be noticed in the consideration of the uses and advantatages of olive oil as has been referred to. He had had, he said, considerable experience in noticing the effects after prescribing that medicinal agent, and that he felt that much benefit had sometimes accrued from its employment. In one case of biliary calculi which was thought to have been malignant in its origin he had used olive oil and the patient recovered. In the more careful consideration of the subject many factors have to be inquired into. Every phase of a case should be most scrupulously observed, and in carrying out such investigation the microscope and every available chemical test should be brought into requisition.

Dr. Crowley said that from what he had observed he was led to the conclusion that about the only beneficial results obtained by the use of olive oil given in cases of obstruction from biliary calculi were from the fact of its laxative action, that its results in such cases are similar to the effects of medicinal agents that have a deterging action on the bowels. He mentioned a case which had been diagnosticated as obstruction from gall-stones, and which was finally relieved by the use of strong cathartics.

Dr. Frisbie, in discussing the subject of obstruction from biliary calculi, spoke of the advantages that may sometimes accrue from the use of laxatives in full dozes; he spoke of cases in which the biliary calculi are small, but obstruction occurs from excess of bile. He also made mention of the occurrence of such calculi being of such size as to occlude wholly the bile passages; it is in such cases usually that surgical measures are demanded. He further made mention of a case of a woman who, while travelling abroad, suffered from severe attacks of pain, which were diagnosticated as the result of gall-stone obstruction. She was advised then to go to Berne, Switzerland, where she was operated on by one of the best experts in such line of work in Europe. Her recovery after the operation was complete.

Dr. Genevieve Clarke said that she had been much interested in the surgical aspect of the discussion, and she was led to conclude from all she could learn that relief in the severer forms of obstruction could only be brought about by resort to thorough surgical measures.

Dr. V. D. Miller said that she was deeply interested in the discussion of the subject of the treatment of obstruction from biliary calculi. She had had a case in which she used olive oil, and had thought that relief had been afforded. She was not quite sure, however, that the symptoms may not return at a later date, and that surgical measures may become necessary.

Dr. Woods spoke briefly upon the subject. He referred to the beneficial results that may sometimes be obtained by the use of laxatives in the less severe class of cases. He recalled the fact of a proprietary medicine, some sort of an extract that had been much vaunted as a sure remedy for gall-stones.

Dr. A. P. Clarke referred to the character of the discussion which had followed the subject that had been so graphically presented by Dr. Marcy, and remarked that it had departed to a considerable extent from the strict line of the theme that had been proposed for the consideration at this meeting. He said that in the discussion of such a subject as was before the meeting it is always well to pause and to consider some of the errors and misapprehensions that one may be in danger of falling into, and that may lead one away from the certainty of arriving at the correct position to be taken. In the consideration of the subject as proposed it is necessary in the first place to recall the fact that the hepatic duct conveys the bile to the common duct, and that the passing of the bile into the gall-bladder takes place only when its entrance to the duodenum is closed, and this closure in the normal condition is said to occur when the stomach is empty. Its route to the duodenum is through the common duct. Its entrance and exit by the way of the gall-bladder is through the cystic duct. Now it may be stated as a self-evident truth that the formation or preservation of the gall-bladder is by no means absolutely necessary for the healthy function of the biliary system. In many mammalia, as in the ass, the elephant, the horse, and the rhinoceros, the gall-bladder is not found. Gall-stones may occur in the gall-cyst and yet produce but little or no trouble. It has not been uncommon to find at an autopsy on persons large calculi in the gall-bladder, and yet there was no history of the patient's having suffered from biliary obstruction. Such concretions

may so block up the entrance of the gall-cyst as to prevent further ingress of bile; this condition would matter but little provided there would be a clear and unobstructed exit of bile from the hepatic to the common duct and into the duodenum. Dr. Clarke said that he well remembered Dr. Marcy's first case of real gall-bladder surgery, as he had been pleased to refer to him as assisting at the operation. The patient, a woman, had long been a sufferer from biliary obstruction. She had become intensely jaundiced. After Dr. Marcy had reached the gall-bladder through an abdominal incision and had securely stitched it to the abdominal wound he incised it, and then what a flowing of bile took place! Quite a large basin was nearly filled. Large calculi from the gall-bladder were then removed, but the bile still continued to flow, of course coming from the hepatic duct. The whole liver appeared to have become engorged. The opening from the gall-bladder into the cystic-duct was practically unobstructed. Had the line of exploration been there stopped the operation would have proved worse than useless. Way down into the common duct other calculi were found firmly wedged. After experiencing no little difficulty in securing a firm hold they were successfully dislodged; the way then to the duodenum had a free opening. The practical experience gained in this case at such an early date in gall-bladder surgery served to illustrate in the most perfect manner the complicated working of the biliary system, and that too in the living human subject. It is unnecessary to say that the patient made an early and complete recovery. When one therefore comes to ask himself of what particular action the ingestion of olive oil could have had on calculi so firmly lodged as those above mentioned, something more than the mere glimmerings of truth in the answer would seem to dawn upon him; then, if not before, that indulgence in such an inquiry could not be other than a mere idle speculation.

Dr. Clarke incidentally made mention of being called to make an autopsy in the case of a woman who had the history of being long a sufferer of biliary obstruction. On opening the gall-cyst, it was found to contain two large stones with well formed facets, the result of reciprocal pressure. Far down in the common duct near the duodenal opening other calculi were met with, and these were tightly impacted. This patient, he was able to state, had long been under the care of a physician who had used very freely both olive and castor oil. If medicines of an oleaginous character could be of advantage in cases of severe obstruction of the biliary passages, they would, it would seem, have displayed themselves to some appreciable extent in the case here referred to.

Meeting adjourned at 6 P.M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Annual Meeting, January 14, 1904, 6 P.M.

HELD AT

Hotel Brunswick, Boston.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

The Thirty-Fifth Annual Meeting of the Gynæcological Society of Boston was held at Hotel Brunswick, January 14, 1904, at 6 P.M. As this meeting was intended to be for a social gathering the reading of the records of the last meeting was omitted. Drs. W. Symington Brown and Albert L. Norris, the committee who had been appointed to nominate officers and committees for the ensuing year, reported as follows: —

For President, Dr. J. Henry Woods.
For Vice-President, Dr. George W. Jones.
For Secretary, Dr. Augustus P. Clarke.
For Treasurer, Dr. Francis E. Carroll.

For Committee on Nominations:—

Dr. Henry O. Marcy,
Dr. Edward P. Wing,
Dr. Eugene G. Hoitt.

For Pathological Committee:—

Dr. John C. Irish,
Dr. Elizabeth C. Keller.

For Auditor, Dr. Jesse F. Frisbie.

The report of the committee was accepted, and the persons whose names were mentioned therein were balloted for and were declared by the president as duly elected.

The report of the treasurer, Dr. Francis E. Carroll, was accepted and placed on file.

At seven P.M., the members, under the escort of the president and secretary, repaired to the dining room, where a repast had been provided for the Society, under the direction of the committee, Dr. George W. Jones.

Dr. Ephraim Cutter, a former member, was present as a guest of the Society, and Dr. Charles Greene Cumston, of Boston, was also present as guest by invitation of the president.

After appropriate remarks had been made by the president, extending a hearty welcome to all on that thirty-fifth annual meeting, he introduced as the first speaker Dr. Ephraim Cutter, who referred, to some extent, to his early experiences in the treatment of pelvic and other internal tumors by means of electrolysis. In this early undertaking he was encouraged by Dr. W. S. Brown, our venerable member, and also by the late Dr. Kimball of Lowell. The needles he then used were large and blunt. He so used the needles that they were made to penetrate the cervix or os uteri as he described his early method of technique; next they were inserted into the rectum, later they were made actually to penetrate through the abdominal wall or into the tumor itself. At that early period there was no reliable galvanometer for measuring galvanic electricity, so he was compelled to rely upon the most sensitive points of touch as that of the tongue. He said that electricity is a form of motion, and it is through this means that a cure or relief takes place; that electrolysis is the result of chemical decomposition. So far as diet is concerned, or the ingestion of certain articles of food giving rise to important agencies in the modification of diseased masses, all depends on the peculiar laws of nature in effecting or influencing the transformation of food into living active tissue and of controlling constructive and destructive metabolism; that we should always regard what we term as nature as our greatest help in the successful management of disease. Dr. Cutter made

mention of some remarkable results obtained by his early method of treatment by electrolysis, and one case in particular he mentioned, in which a fibroid had disappeared and that there had been no return after the lapse of thirty years.

Dr. Irish, being called upon, referred to some of the early cases which had come under the care of the late Drs. Walter Burnham and Gilman Kimball, of Lowell, and of the opposition that was encountered in the presentation of the results of Dr. Burnham's work in that direction. Dr. Burnham removed the uterus, together with the appendages, on account of a large fibroid, in 1853. Dr. Kimball followed Dr. Burnham. Dr. Burnham removed the uterus in nine different cases on account of extensive disease (fibroids) involving that organ, and from this he had three recoveries. After making the necessary incision, the tumor was lifted as far as practical out of the abdomen. All ligatures were brought out of the wound. Dr. Burnham was only second to McDowell in successfully performing ovariotomy, which work he began in 1851. After Burnham, came Gilman Kimball. Peaslee was another operator. The early work in this direction by Dunlap was touched upon by Dr. Irish.

Other speakers who entertained the meeting were Drs. Marcy, Cumston, George W. Jones, A. E. Miller, Vesta D. Miller, Albert L. Norris, and Mary E. Jones. Dr. Burt briefly referred to some reminiscences, but since these as well as the remarks of other speakers mentioned were of a social and personal nature they are not here recounted.

The last speaker was the secretary who though, as he said, was pleased with the success of the evening's entertainment, emphasized the fact that it was most essential for the real maintenance of the Society that the members should as heretofore be ready to respond when called upon for contributions to the meetings.

It having been announced by Dr. Marcy that Dr. Horatio R. Storer, one of the original founders of the Society and

its first and most valued secretary, had been most seriously ill from a grave complication of abdominal disease, it was voted that the secretary be requested to convey to Dr. Storer the sympathy of all present on account of the trying ordeal through which he was passing. In accordance with this vote of the Society a communication was immediately addressed to Dr. Storer. The following is a copy of the note so transmitted:—

CAMBRIDGE, MASS., Jan. 14, 1904.

HORATIO R. STORER, M.D.

My dear Doctor:—At the annual meeting of the Gynæcological Society of Boston, held this evening at Hotel Brunswick, Boston, the fact was there learned with a profound sense of grief to all of the recent illness from which you have so much suffered. As secretary of the Society, I was instructed by a rising vote to convey to you our deepest sympathies and to express our earnest hope that you will soon recover and have many more years of continued usefulness and enjoyment. I hardly need add how much we all feel indebted to you as having been the founder of the Gynæcological Society and having been a most able promoter of gynecic surgery.

I am, with great respect, yours most sincerely,

AUGUSTUS P. CLARKE, M.D., *Secretary.*

In response to the same, the following is a copy of Dr. Storer's note to the secretary:—

NEWPORT, R. I., Jan. 19, 1904.

DEAR DR. CLARKE:—I most gratefully thank you and your associates of the Gynæcological Society for the kind message I have just received. My active connection with the Society, many of whose members of my time are, I fear, now dead, was among my greatest pleasures,—spiced perhaps by the slight measure of opposition that we all as pioneers then experienced. A deal of moral courage was displayed by you and the others, far more than by myself, for I had deliberately burned my bridges, and had therefore little to gain or to lose; but with you, gentlemen, it was very different. It was a very bitter disappointment when broken health compelled me most unwillingly to retire from the contest. The seed that we planted, however, has returned a thousand-fold increase. The general surgeons are now constantly performing many operations deemed unjustifiable or impossible until gynæcologists had led the way by proving the tolerance of the abdominal and pelvic cavities to atmospheric pressure. For

my own safe emergence just now from the surgeon's hands I have really to thank our fellow-gynæcologists of forty years ago. Without their great and self-sacrificing successes, the surgical triumphs of to-day would have been impossible. Dr. Marcy may have told you of my case, that it is of malignant disease. I shall watch its progress with a good deal of quiet enjoyment, for I have had a long and happy life, and have no reason to complain of the way in which it may possibly close.

With best wishes for you, each and all,

Sincerely yours,

H. R. STORER.

The following is a copy of a note which had been previously received by Dr. Marcy, and it is here presented, as it has been thought it would be of interest to the members.

58 WASHINGTON ST., NEWPORT, R. I.,
25 Dec., 1903.

DEAR DR. MARCY: — I fully appreciate your kind letter, and have enjoyed reading the records of your surgical work. My son has perhaps told you of my recent hospital experiences—excision of a segment of transverse colon for carcinoma. I am glad that I myself am the subject and none of my friends. As yet I am able to write but little, but do send most cordially my wishes for your merry Christmas, and very happy New Year.

Sincerely yours,

H. R. STORER.

The meeting adjourned at 11 P. M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Meeting May 12, 1904, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

Dr. Henry O. Marcy read a paper entitled:

"*The Technic of Wounds Incident to Laparotomy.*"

The currents and countercurrents of surgical opinion have nowhere been better shown than in the treatment of wounds. Through the warp and woof of history there is continually appearing and disappearing in the experiences of mankind many truths which have their demonstration only in this later day of crucial science. The Egyptians, the Greeks and the Romans had their various balsams, vinous terebinthinates and mineral oils, and used them as antiseptics with varying degrees of utility. More or less obscurely the ancients recognized the value of drainage and of cleanliness in the treatment of wounds. After amputation, the application of boiling oil or of the actual cautery served an admirable purpose for primary disinfection. Dr. Marcy said that one of the greatest evidences of the high genius and power of Ambroise Paré, lay quite as much in his success in overcoming the conservative prejudice to the introduction of the ligature as an hemostatic as it did in the value of the discovery itself. The late Prof. Henry J. Bigelow, M.D., one day about the beginning of the Civil War, introduced to his class the famous Dr. Mussey as the leading exponent of surgery of the previous generation, with the statement that such a master could easily familiarize

himself within the short period of three months with all the improvements which the generation had contributed to our art. Somewhat recently Dr. Marcy had examined his copy of Heister's surgery, published in 1750, which served as the text-book of Continental Europe for at least three generations, and was surprised at the favorable comparison of that book with works on surgery as late as 1850, especially as far as concerns the technic in the surgical treatment of wounds. His own experience of the War of the Rebellion differs not so very materially from that of a surgeon in the Napoleonic compaigns. It is indeed true that the surgical history of our late war, as written by Surgeon Geo. A. Otis, is the monumental contribution to military surgery, but as he reread it and reviewed his own experiences he had only to lament our lack of present knowledge as exemplified to-day in both military and civil surgery.

The immortal McDowell is justly accredited the father of ovariotomy. He has been sometimes called the backwoods surgeon unhampered by the conservatism of surgical teaching, but such a critic forgets that he probably obtained his inspiration to perform this wonderful service from the Edinborough school then dominated by Dr. Young. He tied off the pedicle with an Indian tanned deer-skin ligature, at that time more or less in common use, for the ligation of arteries. The ligature was cut short and the pedicle dropped back into the abdominal cavity. The subject was taken up with the interest belonging to novelty and its possible importance. The medical journals of the period are replete with contributions, but more especially with dissertations of warning from the seniors who saw little but catastrophe that could result from the imperiling of human life. American inventive genius was fertile in expedients, with which to meet every complication. The mortality rate was necessarily high, and infection the rule rather than the exception.

Very naturally, the cases operated upon presented most formidable complications, since surgery was accepted as a last resort; more commonly frequent tappings had preceded. Adhesions were the rule rather than the exception and multiple hemorrhages common. Drainage was usually insisted upon, even in the most simple cases. The treatment of the pedicle was emphasized as one of the most important factors of the problem. Since in amputation it was the almost undeviating rule that the vessels should be ligated with heavy silk tied very tightly, left long, to serve the purpose of drainage and subsequent removal, so it naturally followed as a common practice to ligate the ovarian pedicle and bring the ligatures, left long, out through the abdominal wound. By the process of sloughing in both instances the ligatures were left ultimately to free themselves by suppuration. A notable exception to this rule was a contribution by Dr. Julius F. Miner, of Buffalo, New York. He called it stripping the pedicle, since he had observed that the ovarian cystoma could be removed from its peritoneal envelope almost without hemorrhage, because the vessels were distributed through it, and did not penetrate the cyst wall. The obvious purpose of this method was to avoid the use of the ligatures and the consequent sloughing; the pedicle was returned within the abdominal cavity often without drainage. A modification of the treatment of the pedicle, as a distinct improvement, was that of Dr. Horatio R. Storer of Boston. He called it the pocketing of the pedicle. It consisted of a separate ligation of the vessels and the suturing of the pedicle to the peritoneum including the free surface of it in the abdominal wound. This, as is evident, was the extra-peritoneal treatment of the stump from above.

The advantages claimed for this method were the ready control of bleeding points within easy reach, if secondary hemorrhage occurred, and the shutting off of the peritoneal

cavity with drainage only of the wound in the abdominal wall.

More or less obscurely the surgeons recognized the occult danger of infection, called by them under the general name of inflammation.

Dr. Sims laid special stress upon the reddish serum, which accumulated within the pelvic peritoneum, as a source or cause of great danger. Obviously to his mind, mechanical means must be provided for its removal. This to many seemed most easily effected by the introduction of a large glass drainage tube to the bottom of the pelvis through the abdominal wound which was to be followed, for a considerable period after the operation, by the withdrawal of the fluid secreted, by means of absorbent or sponge cotton, introduced at short intervals upon a probe, for its absorption. For a very long period, the best operators in the world used the clamp and the cautery in the treatment of the pedicle, experience having taught them that there was a very considerable danger from hemorrhage when the ligature alone was relied upon. This obtained prominence especially from the teaching of Sir Spencer Wells, whose experience was far greater than any other contemporaneous operator, and whose results were equaled or surpassed by no other except perhaps Mr. Thomas Keith of Edinborough. During all this period the abdominal wound was closed by deep through and through silk sutures usually tied very tightly. The profession is indebted to Sir Spencer Wells for especially pointing out the importance of including the peritoneum within the grasp of the suture. This was the technic until modified by the teachings of antiseptic principles. It seemed to Dr. Marcy a safe deduction based upon the experience of Mr. Lister that, if an artery could be occluded by an animal suture cut short and the wound closed to be followed by primary union, the ligature being absorbed and disappearing, that it would be equally safe and advantageous

to close all aseptic wounds with buried absorbable sutures, the subsequent danger chiefly to arise from infection. Given an aseptic wound, no matter how large, well-utilized structures aseptically closed by aseptic absorbable sutures, primary repair will follow.

As the result of his subsequent studies, he determined that the above premises were theoretically correct and that the demonstration should apply equally well to wounds in all parts of the body. He made a series of studies upon the lower animals with the demonstration that an animal suture thus buried in well-vitalized structures was surrounded by leucocytes, that little by little pari passu as absorption of the material took place, the leucocytes became transposed into connective tissue cells, leaving as a permanent resultant more or less well defined vitalized connective structures holding the coaptated parts in firm union. It also was demonstrated that a silk suture was surrounded with leucocytes in a somewhat similar way, invaded in a measure by them, but that absorption and disappearance of the foreign structure very rarely occurred; in a word, encapsulation rather than absorption occurred. Of course such teaching was revolutionary. There are still many doubting critics.

The use of silk, even as a buried suture, unfortunately as he thought, is still common, although the buried absorbable suture is in daily use in every part of the civilized world. Aseptic methods and buried sutures have necessarily revolutionized the technic of abdominal surgery.

In all aseptic wounds very naturally the drainage tube so long maintained as necessary is considered not only useless but dangerous. The pedicle of an ovarian tumor is enclosed by sutures merely to control hemorrhage; the divided structures are covered by intrafolded peritoneum. The consideration for the removal of solid tumors of the uterus presented a much more serious problem. As a rule there was no pedicle which could be treated easily by clamp

and cautery, as by the earlier then advised treatment of the pedicle of the ovarian tumors. This, however, was attempted by many operators. In the seventies he recalled an operation by the late Dr. Kimball, of Lowell, where a fibroid tumor was removed and the stump of the tumor clamped with a large pair of strong forceps, which were advisedly left for some days extruding through the abdominal wound. Suppuration was abundant, and some days later death followed from tetanus. It was a safe deduction, that the cervical portion of the uterus could be closed over with healthy peritoneum, by means of buried sutures, after the removal of a uterine tumor and the abdominal wound closed as in ovariotomy without drainage. This operation was described in its technic and results in a paper by Dr. Marcy before the International Medical Congress at London in 1881. The stump of the uterus was described as closed over by a layer of intrafolded pelvic peritoneum, leaving what was extra-peritoneal *from below*. It would be a work of supererogation to detail to you the currents and countercurrents of opinion in the surgical treatment of the pelvic structures during the last fifteen years. He believed it to be generally accepted that drainage should be limited to septic cases and that here better than ever we understand its importance. In order to avoid adhesions, all pelvic lesions should be covered, as far as possible, by healthy peritoneum, which usually lends itself easily to intrafolding by fine continuous absorbable sutures. The future comfort and welfare of the patient are greatly enhanced by the careful closure of the abdominal wall. There are many manifest advantages in the coaptation of the sundered parts by lines of buried sutures. The peritoneum is carefully coapted including the delicate layer of connective tissue lying behind the recti muscles. The linea alba is similarly rejoined, both preferably by a double continuous tendon suture. A light running sub-cuticular tendon suture completes the

coaptation of the skin. The wound is sealed with iodoform collodion, reinforced with a few fibres of absorbent cotton, and the work is completed for good or ill before the patient leaves the surgery. For good, since like structures are rejoined and are restored to their former completeness and strength. Hemorrhage is scarcely possible, and if the tissues have been maintained aseptically, primary union will follow. It is worse than useless to punish your patient with a bandage, since restoration will be complete and permanent. If imperfect coaptation and restoration have not been obtained, a bandage can by no means remedy the evil. If infection follows, in such a wound, you have left it in the worst possible condition for restoration, since bacterial colonization is likely to follow the line of every buried suture, giving wide areas for infection. Therefore the methods above outlined should never be attempted by one who is not the master of strictly aseptic surgical technic.

Dr. Ambrose Crowley, in the discussion of Dr. Marcy's paper, said that he had been greatly interested in the subject as brought out by the author. Especially so had he been in the fact that Dr. Marcy uses little or no external dressing after he has closed an abdominal wound by the use of aseptic tendon sutures and iodoform collodion. He contrasted that method with that of Mr. Frederick Treves of London, who makes use of many layers of surgical material over the inclosed incision. He said, however, that Mr. Treves had admitted that so much dressing was often quite unnecessary and was not unfrequently burdensome to the patient. Dr. Crowley was inclined to believe that it was so done that the practice of the distinguished surgeon mentioned might be in conformity to the conventionalities of the surgeons of that country. Dr. Crowley asked the reader in regard to the custom of surgeons during the late Civil War as to closing over wounds more or less firmly with bandages and with other surgical dressings or appliances. Dr. Marcy

remarked that the practice of closing wounds, so far as he had seen, was often the custom, and that wounds so dressed almost always became septic and were difficult to bring under control. He made mention of a personal instance of service in helping to treat some four hundred wounded soldiers who had been brought from the Peninsula, Va., some time after the Seven Days' battles had been fought. Nearly all those wounds were not only septic but had become "fly blown" or contaminated with maggots. He spoke of meeting at that time an experienced surgeon, but whose name he has since been unable to recall, who recommended the free use of turpentine as a most excellent detergent to be then used; he was pleased to say that this application proved to be a very effective antiseptic. It was not uncommon in those more serious cases for the soldiers after long exposure and exhaustion to succumb before adequate means for relief could be properly carried out.

Dr. Harmon S. Trueman said that he had seen Dr. Marcy operate in a case of hysterectomy and had noticed the perfect manner in which he kept the wound aseptic; he contrasted that method with the treatment of a case in which the operation for cystoma was undertaken not long since at a public hospital. The operator there, after tying the pedicle, left the silk sutures projecting from the wound, as a means of drainage. Such a wound thus left open must necessarily become septic, or the healing at least be much delayed.

Dr. Joseph S. Lockhart, in referring to Dr. Marcy's method of technic, said that it had been largely adopted by all the best operators of Cambridge and that it was through Dr. Marcy's influence that such grand results had been obtained by the gentlemen there.

Dr. Francis E. Carroll inquired more particularly of the old method of the open wound treatment for injuries, such as occurred during the late Civil War as had been referred to.

Dr. Marcy in his reply said that many wounds at that time were often considered as mortal; that such conditions were usually treated after attempts at what was regarded as the proper surgical procedures, by the application of the usual cold water dressings. Such wounds, as said before, were almost always septic and then it was better to institute measures for drainage than for those of closing up the injuries too quickly.

Dr. W. Symington Brown said that the modern method of treating abdominal wounds was a great improvement over that of the earlier time. He said that it has its drawbacks, as it is often most difficult to maintain such strict cleanliness as had been advocated by Dr. Marcy. To illustrate his point he spoke of a case in which one of the most famous surgeons of Europe happened to realize some time after closing the incision made in an abdominal operation, that he must have left in the abdominal cavity a pair of dressing forceps. On opening the wound next day the instrument was searched for and removed. The patient, however, fortunately recovered. The speaker again emphasized the fact that absolute cleanliness or asepsis of large abdominal wounds is often most difficult to maintain; hence the frequent danger of closing such wounds. Dr. Brown, in referring to his personal observation as surgeon during his service in the late Civil War, said that many wounds were often too tightly bandaged, or so closely that pus could not escape. He believed that the grand results that were achieved during that war were owing to the method of open wound treatment. He instanced the famous case of recovery after the passage of a tamping-iron or bar through the cranium of a man, as reported by Dr. John M. Harlow of Woburn, 1848. The successful issue of the case he had no doubt was due to the fact that the treatment was of an open wound character. Speaking of the pioneer work of the late Dr. Gilman Kimball of Lowell, Dr. Brown said

that though he was a bold operator and sometimes successful, he was nevertheless very rough in his manner. He intimated that the employment of drainage may have been the means of saving some of Dr. Kimball's patients. Dr. Brown, in speaking of the results of Dr. Ephraim Cutter's early attempts in the treatment of uterine fibroids by electrolysis, further intimated that drainage, to some extent, may have have been no unimportant factor after the use of his needles as they were quite large, skewer shape, and as long and quite as thick as the little finger.

Dr. Albert E. Miller said that he had been much interested in the subject as it had thus far been discussed. He realized the difficulties that sometimes arise, in maintaining asepsis in the surgical treatment of abdominal cases, notwithstanding that the surgical art has made wonderful advances.

Dr. Genevieve Clarke said that Dr. Marcy had not only emphasized in his paper the importance of maintaining asepsis in his abdominal as in all his other operations, but that he was constantly illustrating it by his own admirable and perfect methods of technic. The practical application of any excellent method devised is the all important end to achieve.

Dr. Augustus P. Clarke said that Dr. Marcy had well illustrated his teachings by his own personal work. As far as "drawbacks" are to be considered, as had been mentioned by Dr. Brown, they should have no standing as objections to the use of means that will insure, cæteris paribus, an aseptic condition. There should be but one method of abdominal surgery, and that should be the perfect one. Maintenance of asepsis is not only possible but realizable. This has been carried out by Dr. Marcy and by others. The speaker said that he himself also had not infrequently been able to preserve abdominal wounds from becoming contaminated. Properly prepared tendon sutures and the

adoption of the correct method of using them will be found a valuable factor in preventing an aseptic wound from contamination. As regards the treatment of abdominal injuries during the late Civil War he could speak best from the view of an active cavalry surgeon, who soon learned from frequent encounters with the enemy that contaminated wounds, especially of the great cavities of the body, should not be hermetically sealed. The unwritten order in the cavalry arm of service against such irregular treatment was for the most part strictly observed. Many antiseptics and detergents were during the war freely used and with the happiest effect against contaminating influences of the circumfusa. The tolerance of the abdominal and pelvic cavities to atmospheric pressure was not of course then so well known as it has since been, as demonstrated by gynecologists. This revelation, brought about through clinical experience, constitutes in his opinion the most important factor which contributed to the wonderful advance of surgical practice. Liquor sodæ chlorinatæ and liquor zinci chloridi were often freely used by surgeons in preserving cleanliness. Whoever will take the trouble to look over the list of surgical supplies allowed for use by the U. S. Army regulations, will find such articles were issued to the medical officers. So also spiritus terebinthinæ, alcohol, calomel, opium, morphia, and quinia (excellent applications as antiseptics) were often used as detergents or antiseptics. Those wounded, mentioned by Dr. Marcy as he had seen coming from the Seven Days' battles, had all been brought from the hospitals in the vicinity of Savage's Station, which had been under the control of the enemy after the precipitous retirement of the Union army from before Richmond. The speaker said that he was one of the surgeons who was selected to remain with the wounded while left in the care of the enemy. As most of the Union supplies were seized and carried off by the enemy the Union

surgeons became extremely handicapped. The cause of the maggots appearing in the wounds of the soldiers, as spoken of by Dr. Marcy, was owing partly to this cause and partly to the excessively hot weather and to limited supply of pure water and also to the vile and sickening odors arising from the many unburied bodies of animals as well as of men (both Union and Confederate) lying exposed to the hot sun on the several battle fields in the vicinity of swamps, where swarms of mosquitoes by night, and the green flies by day, seemed to vie with each other in the exercise of their fiendish errands, at the expense of the hapless fallen soldier. As for the fitness of the military surgeons appointed for the great work entrusted to them during the Civil War, they should, for ability, skill and patriotism, be regarded as most superior. The several volumes of the medical and surgical history of that war as compiled under the direction of Surgeons George A. Otis and J. J. Woodward and published by the authority of the Government, are a lasting monument to the great sacrifice of the army surgeons and show a record for skill and achievement that has never been surpassed by any other military or naval contingent. There can be no doubt that the great success gained by the surgeons during the Civil War were far more influential than was any form of Listerism in helping to prepare the way for a more brilliant outcome of the gynecologist and abdominal surgeon.

Dr. Marcy was next called upon to close the discussion. He dwelt again with much emphasis upon the necessity of maintaining asepsis in the management of wounds, particularly in those incident to laparotomy. In what class of cases, he asked, shall drainage be resorted to. Mr. Lister, he said, had at first employed drainage very frequently, but later he trusted more to the supposed antiseptics in the form of a spray from an atomizer. Though, as Dr. Marcy said, he owed much to Mr. Lister for his early teachings, as well

as to the late Dr. Marion Sims for the new and improved methods which that operator had put forth, he nevertheless found it necessary after starting his own professional career to develope a method of technic on which he could himself rely. The surgical treatment of hernia embraced some of the more important themes he had to consider. In that early work he encountered more or less difficulty in obtaining endorsement for attempts at such operative procedures. He spoke of having performed since some four thousand laparotomies without finding it necessary to resort to drainage. In four of his cases in which death took place, there were numerous adhesions and other serious and irremediable complications. The thought of the laparotomist, he finally said, should ever be on the subject "the aseptic toilet of the peritoneum and how best to make and guard that condition."

Meeting adjourned at 6 P. M.

AUGUSTUS P. CLARKE, M.D.
Secretary.

Meeting November 10, 1904, 4 P.M.

HELD AT THE

Boston Medical Library.

The President, J. Henry Woods, M.D.
The Secretary, Augustus P. Clarke, M.D.

Dr. Jones read a paper entitled "*Clinical Record of Cases.*"

The first case was that of Mrs. B., American, aged 30 years. It was a case of double pyosalpinx, in which he operated, May 1, 1902, and in which there was complete recovery. As a girl, the patient was robust and of good health. She married at sixteen years of age. Soon after marriage she became pregnant, but early aborted. During the next five years she had other abortions. She had had one child which was aged five years. Seven years before the patient was seen by Dr. Jones, she had a pelvic abscess, which had to be incised and which was allowed to drain through the vagina. The abscess recurred several times, in each of which the suffering appeared to be augmented. Though her own personal history appeared to have been previously good, her husband, it seems, had contracted an attack of gonorrhœa a short time before the occurrence of the first abscess. When seen by Dr. Jones, the patient had been suffering from a severe and continuous pain in the ovarian region. There was much tenderness on pressure, and there was evidence of enlargement of both ovaries. There had been repeated chills and febrile reactions with a temperature of 102.2°. The symptoms

both rational and physical pointed to the existence of suppurative pelvic processes. It might be further said that the vaginal examination revealed the fact that there were hard nodular masses at the fundus uteri, and that the Fallopian tubes had become enlarged and abnormally tortuous, and that much induration of the surrounding structures had taken place. The diagnosis, as before remarked, was double pyosalpinx. Operation was advised and was performed May 1, 1902. The operation proved to be a difficult procedure, owing to the fact that the patient was very obese and short in stature. A median incision made showed that the peritoneum was not only red but abnormally soft and fragile, from the previous inflammation. Hemorrhage would be excited by making the slightest touch on the exposed parts. There were numerous adhesions, which necessitated the taking of much time and care in their removal. Both ovaries were found to have become cystic; the tubes were enlarged to the size of the finger; they were bent and tortuous, and were filled with purulent exudation. The removal of these was found to be difficult, as before remarked, in consequence of the result of the inflammatory processes. The wound was previously packed with gauze as a precautionary measure in case there should be rupture of the abscess and the escape of pus. Both ovaries and tubes, with a considerable segment of both cornua of the uterus, were removed. One tube did, however, rupture while being ablated, and some of the contained pus escaped, but was taken up by the gauze packing, and was quickly removed. The parts were carefully wiped and afterward disinfected with sterilized salt solution. Tendon was used for ligatures and for sutures. The abdomen was closed, though provision for drainage was made. Recovery was uninterrupted for fourteen days, after which time a small stitch abscess pointed at the lower angle of the incision; this had to be incised; about a half teacupful of pus

escaped, including some of the ligatures with a knot. This stitch abscess discharged at intervals from four to five days; small bits of tendon also came away. The abscess finally healed after the lapse of three and a half months, the patient in the meantime gaining and proceeding to full recovery. It is now two and a half years since the operation was undertaken, and the patient says that she has had the most perfect health of her life, but she is surprised that she should menstruate as regularly as formerly. The recurrence of her menstruation now raises the question, said Dr. Jones, respecting the function of the tubes and ovaries as regards the menstrual process in woman.

Case 2, Mrs. D., aged thirty-nine years, American, housewife. This was a case of cancer of the vagina and of the uterus. She was seen on June 18, 1898. History and treatment: — The patient had been in fair health until within two years of the time at which she was first seen by Dr. Jones. She was rather stout, though well-proportioned and of good complexion. Appetite was good, notwithstanding she had suffered from the effects of constipation. The menstruation first appeared at the age of sixteen years; it was normal in amount, but it was, it appears, attended with unusual pain. Her mother died of pneumonia and her father of cancer. One sister, it was said, had cancer, from which she died. She had two other sisters, one of whom complained of symptoms indicating cancer of the uterus; the other sister suffered from gastric pain and from constipation, and presented a cachectic condition which led to the suspicion that she might be the subject of a malignant disease. This patient (Mrs. D.), had had far more than the usual disturbance during the time of the menstrual discharge; the flow was excessive, and it occurred at times during the intervals of the menstrual periods. She had pain and much tenderness in the vaginal parts, especially during coition, which was liable to cause more or less hem-

orrhage. She first consulted a physician, a month before coming to Dr. Jones for advice, but had refused examination, until a few days prior to being seen in consultation by him, who agreed as to the diagnosis of cancer. Dr. Jones advised hysterectomy, which was assented to, and which was undertaken at the patient's house, June 18, 1898. On section of the abdominal cavity, there was found considerable involvement of the mesentery, intestines, broad ligaments, and ovaries. The numerous adhesions extending in almost every direction rendered the operation in the case very difficult, and one of the worst, said Dr. Jones, that he had ever had to deal with. The patient unfortunately died from the effects of shock and the consequent exhaustion twenty-four hours after the operation.

Case 3, — seen May 26, 1898, was that of Mrs. M., aged twenty-three years, housewife, who had suffered from the effects of dysmenorrhœa, which finally gave rise to convulsions. Patient had been married three years. She was well from childhood until the age of thirteen years, when she became a great sufferer from the dysmenorrhœa, as mentioned. The menstruation occurred at irregular intervals: sometimes it was profuse, and at other times it was small in amount. The patient was of a constipated habit; the appetite was variable. In the intervals between the menstrual periods the patient appeared well. When Dr. Jones was first consulted he found her suffering from a painful attack. The pain and tenderness extended over the whole of the abdomen, particularly over the right ovary. The pain extended also along the thigh. A week later, which was June second, while making an examination there was found a marked retro-flexion of the uterus and stenosis of the os uteri. The right ovary was enlarged and had apparently become cystic. Dr. Jones advised rapid dilatation and curettement of the uterus. On June fourteenth Dr. Jones was again called, when he found the patient suf-

fering from an abscess of the right labium majus, which he opened after the lapse of twenty-four hours. Fully a half teacupful of foul pus escaped. The patient recovered from this within a few days. On June twenty-second, the patient being etherized, the uterus was thoroughly dilated and the parts were then treated by the application of tincture of iodine, and carbolic acid of the appropriate strength. Recovery was rapid. The patient has since given birth to a child at full term. Menstruation returned in due time and has been regular and unattended with pain.

Case 4. — Occurred in that of Mrs. D., American, aged thirty-four years, a housewife. The patient had a multilocular fibroid. During childhood she suffered but little on account of sickness. She began to menstruate at the age of fourteen years. She had been, however, rather irregular until within the last six months. Some ten years before marriage, which was eighteen years ago, she was employed as a bookkeeper, and during that period of time she had only four days of illness. Married October 18th, 1896. Two years ago last summer she had a fall which was attended with more or less internal suffering. In September before marriage she had an attack of dysmenorrhœa. She had three painful attacks after that one. During the past six months, before being seen by Dr. Jones, she had noticed an increase in size of the abdomen. She had also a cough and some vomiting, which were undoubtedly of a reflex character. The mother of this patient had noticed that she had become irritable; this condition in her daughter was, the mother said, quite unusual. The patient had had no hemorrhage. Her paternal grandmother suffered, as it appears, from a similar trouble. Her maternal grandmother had "cancer of the liver." Examination of the patient showed that there was a multiple fibroid tumor of the uterus. Hysterectomy was performed Jan. 25th, 1898,

which resulted in recovery after three months. The patient reported herself as still in sound health.

The fifth case was that of Mrs. C., aged thirty-two, Irish-American, a housewife, Dec. 6, 1897. Diagnosis was threatened abortion during the second month of pregnancy. The temperature being 103°, the operation of curettement of the uterus and of the removal of the placenta was done Dec. 7, 1897. Dr. Jones was called to see the patient, Monday evening, Dec. 6, 1897 — he then found the patient with a temperature of 102.5°. She had had chills and much severe pain in the abdomen. The patient then gave the following history. She had passed the second menstrual period and had supposed that she was pregnant. One month before, having missed the menstrual process, she sought out an abortionist, who pretended to pass into the uterus an instrument several times during the course of three weeks without effecting any direct result as regards the visible expulsion of the fœtus. The patient then herself passed a catheter into the uterus as she had done, as she said, many times before; still she failed this time. She then went to another abortionist, who did something which gave rise to intense pain and hemorrhage. The patient becoming alarmed sent that night for Dr. Jones, who found her, as said before, with a temperature of 102.5°, and with other symptoms, as above mentioned. The diagnosis was the initial stage of septicemia. He advised curettement, which he performed with the help of Dr. John Z. Currie, on the morning of the seventh of Dec. There was removed the necrotic remains of a placenta, but no fœtus was seen. The temperature at that time was 103°, but after eight hours it was only 100°, when the patient was able to rest quietly. She made a rapid recovery.

Case 6 was that of Mrs. L., aged twenty-nine years, a saleswoman, who had suffered from the effects of dislocation of the coccyx, the result of traumatism. The date

of the case was June 7, 1897. As a girl she was regarded as in good health, except when she suffered from disease incident to childhood. Later she suffered from an attack of acute rheumatism. Menstruation began at the age of fourteen years, and was quite regular and painless until within a few months of being seen by Dr. Jones. Bowels were regular, though the appetite was not very good. She suffered from frequent attacks of headache and from pain, particularly in the lower part of the back. The patient was unable to sit on any seat, even if it was cushioned, for more than a few minutes, without experiencing much discomfort. She could not walk, or even recline backward, without such position causing much uneasiness felt along the spine and legs. Examination showed that the coccyx was dislocated, and its position was that of right angles to the sacrum. The terminal end or portion had become much enlarged and was exceedingly tender to touch. There was prolapsus uteri: the os uteri rested on the point of the coccyx. The patient mentioned that when she fell some years since the force of the fall was for the most part centered upon the coccyx. She entered the hospital July 10th, 1897, when Dr. Jones, on July 12, removed the coccyx as high up as its union with the sacrum. After one month from its removal all pain had ceased and the patient was able to sit without discomfort; by this time all subjective symptoms had also vanished. A year later the patient was found to have fully recovered her health.

The 7th and last case was that of Mrs. M., aged twenty-nine years, of Scotch descent, a nurse. The date of the case was May 28, 1897. The diagnosis was endometritis with retroversion and prolapse of the uterus. The patient was unmarried. Her menstruation began at the age of 16 years; it was regular and painless. Four years before the patient was seen by Dr. Jones, she had injured herself while attempting to lift a heavy trunk. The patient felt,

as she said, "a snap," and immediately had pain in the lower part of the abdominal region. Soon after, she realized an unusual pressure resting on the rectum. She experienced soon after much difficulty in defecating. She also had pain during the next menstruation. She consulted a physician who found that she had incurred retroversion and prolapsus uteri. Three and a half years before being seen by Dr. Jones a physician, whom she consulted, inserted a pessary which she did not remove for some three months. Owing to gastric pain and other distressing symptoms she was obliged to remain in bed. Dr. Jones finding on examination marked endometritis accompanying the retroversion and prolapse of the uterus, advised resort to surgical measures for relief. On May 31, 1897, after curetting thoroughly the uterine cavity he performed ventrofixation. Recovery was speedy. January, 1903, the patient reported as being in good health. She has had no trouble since the operation, though she has been very active in her work. Examination has shown that the uterus is in its proper position, and that its functions are normal.

Discussion. — Dr. W. S. Brown mentioned a case of a woman seen several years since, who was aged sixty years, and who had noticed that she had enlargement of the abdomen. The condition was attended with considerable pain. Dr. Brown being consulted thought first that the enlargement might be due to the presence of an ovarian tumor. Three different consultants, including the late Dr. Kimball of Lowell, being also called in, felt sure that the case was that of ovarian disease. He had also called to the case Dr. John Homans, who agreed with the other physicians as to the diagnosis that had been made. An exploratory incision showed that the disease was not ovarian. The wound was closed without proceeding further in the operation; the patient recovered from the effects of the operative interference and was well for some six months,

when the disease returned and led to fatal results. Dr. Brown remarked further that he thought in such cases, when there was considerable doubt as to the diagnosis, it was wiser to defer operating until a better understanding of the case could be had.

Dr. Marcy exhibited two specimens of biliary calculi which he had removed by operation from a patient who had been under the care of some four or more physicians. The patient had had jaundice. The gall-bladder presented a dark or dusky appearance. He also showed other specimens of gall-stones, one of which was quite large, the other was smaller. He showed a gall-stone which had produced necrosis of a rib. The gall-stone had evidently migrated to the rib, for a distance of a half an inch or more. Dr. Marcy spoke of having had another case in which he thought that there was a gall-stone or a biliary obstruction. He opened the gall-bladder, the discharge then became profuse, being nearly three pints of bile a day. The patient had been a great sufferer. Not long since, Dr. Marcy operated in a case in which he thought there were biliary calculi. After dissecting up the biliary passages he created an artificial union from the gall-passage to the duodenum, by the use of Dr. Harrington's device, which he found to be easily applied, and which after perfect union of the parts was passed in due time per rectum. Dr. Marcy spoke of the advantages of the operation for removing of the coccyx in those cases in which old fractures or other injuries to the parts have rendered the sufferings of the patient intolerable.

In answer to Dr. Jones's questions which he raised respecting the recurrence of the menstruation in the case in which he had removed the uterus, including the ovaries and Fallopian tubes, the secretary, Dr. A. P. Clarke, remarked that the occurrence of the menstrual discharge is not dependent altogether upon the existence of the mucous

membrane of the uterus and its adnexa, but the discharge may proceed from any portion of the genital tract, as from the mucous membrane of the vagina. Menstruation is a "periodical discharge of the lymph corpuscles," which are not carried off by the lymphatics, as those organs of absorption are not sufficiently developed for this function in woman and the higher simian types.

In reply to a verbal remark made by Dr. Jones, while reading his notes, whether he did right in advising curettement, and the removal of the necrotic placenta in the case (No. 5) of the patient who had been instrumental in trying to effect an abortion in the manner she had undertaken, Dr. Clarke remarked that Dr. Jones most assuredly did act wisely, especially so did he in calling to his assistance another distinguished physician who could have been a witness if necessary of the statements of the patient and the existence of the necrotic secundines that were removed through the operative interference. If Dr. Jones had finally refused to act in such case of a woman who was in imminent danger, and matters had further gone wrong with her, he might have been put to the unpleasant necessity of proving the truth of the patient's statements made to him, and of defending his reputation against the result of the happenings of an unfortunate occurrence.

Adjourned 6 P.M.

AUGUSTUS P. CLARKE, M.D.,
Secretary.

Meeting May 11, 1905, 4 P.M.

HELD AT THE

Residence of Dr. Henry O. Marcy, 180 Commonwealth Avenue, Boston.

The President, George W. Jones, M.D.

The Secretary, Augustus P. Clarke, M.D.

The records of the last meeting were read and approved.

Dr. Frank L. Burt made mention of how he had recently used a specimen of glass drainage tube that was commonly employed as far back as in the early eighties. Dr. Burt was called to a case of a woman aged twenty-three years, who while attempting to insert a common lead pencil of six inches in length into her genital tract, passed it by some accident into the meatus urinarius and lost it in the bladder. The patient had waited some forty-eight hours before seen by Dr. Burt. He first exposed the meatus to a good light, then passing a glass tube of a requisite calibre through the meatus he succeeded after some difficulty in making the pointed end of the pencil enter the glass tube sufficiently to allow it to be withdrawn from the bladder while it was inside of the tube. The pencil in the tube as it had been removed from the bladder was shown to the Society. No serious result followed the occurrence of the mishap to the woman.

Dr. John C. Irish read a paper entitled "Gastro-Intestinal Surgery."

Ten years ago, the author thought that we would have all agreed that in abdominal surgery, so far as any new operations were to be considered, we had then reached the limit. We would have all said that any future advance in this field would be merely along the line of improved technic, and not at all in the way of new operation. This conclusion we must now emphatically modify, for there has been added to the others within the last three or four years a group of abdominal operations which deal particularly with the results of the diseases of the stomach and of the upper portion of the duodenum. These several operations are referred to under the general term of gastro-intestinal surgery. He chose this subject, he said, for his brief remarks because he believed it involved more important and more unsettled surgical questions than any other. This expedient embraced in the term gastro-intestinal surgery is still on trial. The practice has so recently sprung into existence that its future success and the ultimate benefits that it will confer upon a large class of patients, the future will have to determine.

Personally, he believed that in cases of cancer of the stomach and duodenum, stricture of the pylorus, gastric ulcer, and dilatation of the organ, the benefits that may ultimately be conferred will greatly exceed our present expectation. He spoke of these operations, he said, as a new surgery of the last three or four years. This statement of course is not absolutely correct, because the first radical operation for cancer of the stomach was successfully performed by Bilrloth in 1881. During the next twelve years some work was done in this department of surgery, but with rather discouraging results. Then about 1893, with the advent of the Murphy button, a new impulse was given to gastro-intestinal surgery and the progress in the surgical treatment of diseases of the stomach and duodenum steadily advanced, but it is since the beginning of 1900 that the

principal work, in this line of surgery, has been done. The change in the technic of the former operation and the new operations that have been added are so great and so many that we may fairly call this a new surgery of the past four years.

The evolution of this new surgery has, as he said, been in the main accomplished within the past four years, and very largely by the work of the Mayo Brothers,* Murphy, and Deaver of this country, and by Moynihan, Mayo Robson, Mikulicz, Czerny, and others of Europe.

Dr. Irish thought that much more progress has been made by our European confrères than by the surgeons in this country. This is certainly true, he said, if we except the wonderful work done in this direction by the Mayo Brothers of Rochester, Minn., the latter reporting a total number of three hundred and three cases with a percentage of success markedly better than occurs in the recorded statistics of any other operators so far as he knew.

In tracing the history of all the old abdominal operations, as for example, ovariotomy, hysterectomy for fibroids or cancer of the uterus, gall-bladder surgery, and operations for appendicitis, we observe, he says, a simple steady advance in the results of these operations. The progress made in all of them has come about in part by continually improving the technic, and in part from increasingly earlier interference. The advance in all of them has been slow and steady. On the other hand, in gastro-intestinal operations, taking all the cases from the beginning, in 1881, by Billroth, up to five years ago, there had been but very little advance in the favorable results, and over fifty per cent. of the operations were immediately fatal. All of a sudden the frequency of gastro-intestinal operations increased several times, and as suddenly the fatality diminished to about twenty per cent., taking the whole number of operations

* Drs. C. H. and William J. Mayo, of Rochester, Minn.

together. It is interesting to inquire why there should be this difference in the history of the two classes of abdominal operations and why there should have been so sudden an improvement in gastro-intestinal surgery as all at once to take it out of the class of surgical operations of doubtful utility, and to establish it as one of our most important resources in dealing with affections that are quite common and very fatal. Dr. Irish believes that this change has come about, first by improved diagnosis of stomach affections, by early operation, by very radical changes and improvements in the technic of these operations, and by the much wider range of diseases of the stomach that are now submitted to operation. In the matter of diagnosis of the diseases of the pylorus and duodenum, the experience of four or five thousand gastro-enterostomies that have recently been done has let in a flood of light and corrected many errors. This has been done to such an extent that many of our old diagnostic theories have been proved to be entirely unsound; for instance, not many years since, when we saw a patient with quite constant vomiting and obstinate constipation, rapidly emaciating, and especially if we could find a distinct tumor at the pyloric end of the stomach, at the right of the umbilicus, we invariably pronounced it a case of pyloric cancer, and at once decided that nothing could be done. In those cases in which no tumor at the pylorus could be found, and we had a somewhat profuse vomiting of blood, the question then arose whether we had a cancer or an ulcer of the stomach to treat. Then recalling the fact that the pylorus is the seat of cancer more often than any other part of the body, the law of possibilities was in favor of the correctness of our diagnosis. But in the light of our present experience with gastro-intestinal surgery he believes that it is well established that more than one half of those cases that were formerly diagnosticated as cancer of the stomach were really instances

of benign diseases, and as frequent as cancer of the pylorus really is, it is perfectly well settled that pyloric or duodenal stricture of a benign character is much more frequent than cancer. This statement he thinks is now a well recognized fact. A personal experience which came to Dr. Irish last August impressed upon him one of the unknown number of errors of this kind which had often been made.

August 4, 1903, he was called to Nashua to operate upon a patient for pyloric stricture. When he saw the patient he was reminded that he had seen her eleven years before. He found that the patient had a tumor at the site of the pyloric end of the stomach, and had what he thought was a cancerous cachexia, and was rapidly ematiating with persistent and uncontrollable vomiting. He at once concluded that the patient had cancer of the stomach, and that no operation would be of benefit to her. It seems, however, that the patient recovered from the condition, or nearly so, although she was suffering somewhat from digestive disturbances. For the past two years her digestive symptoms had grown slowly and steadily worse. She had more or less vomiting, was unable to retain anything but bland, liquid foods, and again was rapidly emaciating and constantly suffering from very severe gastric pain. Finally, when he saw her on August 4th, she had as much the look and history of cancer of the stomach as she had had eleven years before; but this time, however, there was no tumor over the pylorus. The patient insisted upon an operation for relief of pain. Her age was sixty-eight years, and she was really in a starving condition. Dr. Irish started to do a gastro-enterostomy, but as Mrs. D. was so feeble and bore the operation so badly, he changed his plan of procedure, and did merely a pyloroplasty. The condition found was that of a close stricture of the pyloric end of the stomach, with no evidence of any cancerous disease. This state was the result of the contraction of scarry tissue

following upon the gastric ulcer, which eleven years before had been concluded to be cancer. The patient was so exhausted at the time of the operation that she never fully rallied from the ordeal, and died five days later. The autopsy showed that nothing had gone wrong in the abdomen as results of accidents in the operation. It was in fact that surgical interference was resorted to too late to be of any avail.

He reports this case, he said, not because it carries any special interest in itself, but merely as an example of the way misapprehensions arise, which probably all of us have made in the past in endeavoring to make a differential diagnosis between cancer at the pylorus and benign stricture at the part. He wished, he said, to emphasize the importance of not confounding a curable disease with one that is malignant. Of course we are liable to encounter, however, cases of stricture at the pylorus in which the diagnosis between the benign and the malignant disease will be difficult or impossible to make. When we recall, nevertheless, that in many cases stenosis is a remote effect of the healed gastric or duodenal ulcer, the preceding history of the case may afford us material assistance. When we find in the history of the patient at some preceding time a prolonged attack of indigestion, accompanied with more or less vomiting, and especially that of blood, we must reasonably conclude that the patient has had an unrecognized gastric ulcer, and that the present condition is due to the contraction of the scarry tissue that has followed the ulcer. This, however, does not make an absolute diagnosis between a benign and a malignant disease, for cancer is very often located in the scarry tissue that follows upon the preceding ulcer. Lebec says that "about 10 per cent. of all gastric cancers have their origin in benign ulcers." Dr. J. B. Murphy of Chicago in this connection lays great stress upon operative interference in all cases of gastric

ulcer as a prophylaxis against cancer. Again, recent gastro-intestinal surgery has demonstrated that gastric ulcer is quite a common affection, and that it frequently goes on to recovery without having been clinically recognized.

A few years ago we were accustomed to regard dilatation of the stomach as an idiopathic disease. This condition was supposed to be due to an inexplainable stretching, or to an atonic state of the parietes of the stomach. He supposes that there are some cases of dilated stomach that are idiopathic; in other words, there are cases in which we can find no cause for such a result. Dr. Irish believes that in the great majority of cases, if not in nearly all of them, dilatation is due to some mechanical condition. An occasional case may result from gastric ulcer, but generally it is the sequel of a mechanical obstruction occurring at the duodenum or at the pylorus. Therefore, usually, with some exceptions, as soon as we discover an excessively dilated stomach we may conclude that we have likewise a pyloric obstruction as the cause. The four thousand gastro-enterostomies performed have demonstrated the certainty of this fact.

Finally, in summing up the essential points relating to the question of gastric affections, we find that we must modify our former conclusions that they may appear as follows: first, that pyloric obstruction is more often in character benign than malignant, and therefore curable by surgical means; second, that many cases of prolonged and severe indigestion are due to gastric ulcer, another condition which is curable by operation; third, that dilatation of the stomach in a majority of cases is due to one of the two preceding conditions, and therefore is curable. Hence of the stomach diseases we have pyloric obstruction, gastric ulcer and dilatation of the organ itself that Dr. Irish would class as distinct surgical affections, and which should be treated by radical surgical means, either by resort to

pylorectomy or to gastro-intestinal anastomosis. In all cases of dilatation of the stomach surgical interference is called for. When we have determined that condition of excessive distention, there is no question, says the author, as to the necessity for an operation, even if the case should prove to be one of those so-called idiopathic cases, in its inception. The best treatment for this last is by recourse to gastro-enterostomy, because that procedure supplies drainage for the stomach, which is most essential in the condition for effecting a cure.

Whether in pyloric cancer of the stomach a radical operation, as that of pylorectomy, should be undertaken or not, will often be an important question for consideration. By some surgeons, a distinct tumor at the pyloric end of the stomach is judged to be a contra-indication because it is believed that the disease has already advanced so far that any radical interference will prove hopeless, and this certainly will be the case whenever there is a distinct cachexia and a considerable general debility. In those cases in which the diagnosis has been made early, and in which the patient's general condition is good, ablation of the disease, so to speak, by pylorectomy will give a quite satisfactory result. Peterson of Heidelberg reports fifty-seven cases of resections of the pylorus for cancer. The mortality in the first twenty-four cases was thirty-five per cent.; in the last twenty-three cases the death rate was seventeen per cent. The Mayo Brothers report twenty-seven cases with twenty-two recoveries. This operation of pylorectomy, or more correctly perhaps, partial gastrectomy, has been so recent that the final results in regard to recurrence of the morbid process cannot at present be determined.

One writer, however, claims that of these operations, twenty per cent. has been permanently cured. At any rate, with early diagnosis and early operation in cancer of the pylorus the outlook seems to be steadily brightening.

On the other hand, when we have a perceptible tumor, a distinct cachexia and debility, with vomiting and extreme pain, it may be questionable whether a palliative operation of gastro-intestinal anastomosis is advisable to attempt. In these instances operations are followed by quite a large immediate fatality, or probably by about that of thirty per cent. Mikulicz says that the relief from suffering is so great that the operation should always be done. It is estimated that life is lengthened thereby, on an average, of about four months. In the surgical treatment of these gastric affections the operations at our command are practically reduced to three, namely: pyloroplasty, gastro-enterostomy, or uniting the stomach by artificial anastomosis to either the duodenum or the jejunum, and pylorectomy. Pyloroplasty is the simplest operation to perform, but as it so often fails to drain the stomach it should be rejected, except in those cases in which the patients are so feeble that gastro-enterostomy cannot be safely done.

Formerly, Murphy's button was almost universally used in making gastro-intestinal anastomosis. In the first place it was effectual, and secondly, with it the operation could be rapidly completed in comparison with the tedious, interrupted sutures. But since we have learned to use a running suture of fine silk or linen, and that we may go through all the intestinal coats in the sewing, this method of union is rapidly replacing the use of the Murphy button. The use of the continuous suture, Dr. Irish believes, is a distinct advance over the employment of the button for artificial anastomosis.

The favorable results in all these operations of gastro-intestinal surgery is largely dependent on the skill and perfection of the technic; yet it is of the greatest importance for one to remember that this entire class of patients with organic gastric lesions is for the most part suffering from the results of defective nutrition. Their vitality and resist-

ing power are being constantly undermined, and they bear such operations at great disadvantage. Consequently the success of the operation is largely dependent on reaching an early diagnosis, and on having early resort to the surgical treatment.

Discussion. — Dr. Jesse F. Frisbie reported a case of gastro-intestinal trouble which had been of some years duration. The patient was fifty-eight years of age and had suffered from more or less vomiting, especially after partaking of meals; the agony of the patient was often intense, and required large doses of morphia to keep it under control. At a later stage the patient vomited large amounts of blood, and at times blood that was coagulated. The patient had consulted several surgeons, but the disease was regarded by all as malignant and therefore hopeless. The case went on nearly fifteen years, when it ended fatally. The autopsy showed that there was no cancerous or other malignant condition. The cause of the suffering proved to have been the result of constriction at the pylorus, attended with suppurative changes of tissue. Dr. Frisbie also made mention of the case of a woman, who was operated on for the removal of a Murphy button, that had been employed in a case of intestinal anastomosis. The button was found at the point of insertion, near which profuse suppuration had taken place.

Dr. Edward P. Wing spoke on the importance of making, if possible, an early and correct diagnosis. Every reasonable means to that end should be employed. The vomited matter will, through the use of the microscope, be sometimes helpful in aiding to reach the diagnosis.

Dr. Genevieve Clarke remarked that the subject of the paper as brought out by Dr. Irish was of unusual importance. She believed that many cases of pyloric stricture have their starting point in the neglect by the patient to make a proper choice of articles of diet; this may lead to

gastric irritation, and to more or less imperfect digestion and later to inflammation about the pyloric orifice, and to consequent induration and enlargement of the part. She concluded from her own observation that if palliative medical treatment, including the careful selection of food for the diet, does not soon prove sufficient to allay the disturbance, relief by surgical means, as had been proposed by Dr. Irish, should be had recourse to.

Dr. Mary E. Jones had been much interested in the subject as presented. She asked the reader whether he at any time could of his own accord have recommended the operation in the case of the patient that he had reported. His reply was that he could not, but the operation was done nevertheless with the hope that relief might follow its performance; the patient had long been urgent for an attempt to secure help through surgical interference. She spoke of a case of a woman who had suffered for a considerable period from gastric disease. The patient had consulted many American surgeons; they had all agreed that the affection was cancerous. The patient next visited Russia and obtained there the same opinion; she afterward went to Berlin, where she consulted an eminent surgeon, who diagnosticated the case as not malignant, but as tuberculous, as it subsequently proved to have been.

Dr. Harmon S. Trueman spoke of a case simulating cancer of the stomach at its pyloric portion. The patient vomited seemingly everything which she took. She at one time became very much exhausted by the incessant vomiting, extending over a considerable period. Later, she rallied somewhat and gained in flesh but never became strong enough to bear the strain incident to a resort to a gastro-intestinal operation. Dr. Trueman spoke of the important work done in this direction by Dr. Munro at the Carney Hospital, and he incidentally remarked that the diagnosis of a case has often to be revised after the abdomen has been opened.

Dr. Frank L. Burt, in discussing the subject, said that the cases as they present themselves can be divided into two classes, cases medical and cases surgical. The distinguishing feature between these two classes of cases is often practically very difficult to determine. He had seen several cases that had been treated as cancerous and yet the symptoms were due to other causes, as the accumulation of fæcal matter. In such cases of gastric disease giving rise to pain the cause was due to adhesions of the intestine. In one case he found on abdominal incision the adhesions of the intestine were very firm and the coats of the intestine as thick as his thumb. He had only to overcome the adhesions for the relief of his patient. Many of his cases were relieved by having a mere resort to medical measures.

Dr. Augustus P. Clarke, speaking of his own experience as well as of the work that had been done in other places, said that the grand results so lately achieved in gastro-intestinal surgery were in large measure due to experience first gained in gynecic surgery. We have for some time come to realize that continued and repeated irritation may be productive of cancer or other malignant disease. The results of the action of the ingestion of improper food, or of the partaking of improper drinks, may lead to serious gastric disturbances, and particularly may they do to that portion of the stomach in the vicinity of the pyloric orifice. Many varieties of food that are not infrequently partaken of are not readily acted upon by the gastric tissues and are therefore delayed in their passing through the pylorus. Such substances are thus liable to cause irritation or inflammation which may lead to hypertrophy or induration of the pyloric structures, or at least to a condition of spasm of the sphincter pylori and to more or less closure of the orifice at that part. The stomach from such a state of the pylorus is liable to become unduly dilated, its position undergoes alteration, the organ itself becomes the nidus for bacteria and the seat where other

disturbing factors may arise. Pain, vomiting and many distressing symptoms later occur, which can be relieved only by resort to appropriate measures of treatment. In those cases in which material benefit through therapeutic measures, including the proper use of the stomach tube and irrigation, cannot within a reasonable time be gained, the speaker was inclined to favor resort to surgical interference, as had been proposed by Dr. Irish. Dr. Clarke further incidentally remarked that in those more desperate cases which occasionally occur it always becomes an additional stimulus to the surgeon to proceed in his work if he can be assured that the patient is ready and urgent for a trial of the advantages that may possibly accrue by resort to any surgical measures that he may undertake.

NOTE.—[It is worthy of remark that one of the most important functions of the stomach, or of the gastro-intestinal organs, is to initiate and to furnish mechanical and chemical motion, which being affected by the nerve ganglia in the vicinity is capable of being transmitted as by an electric current to the cardiac, arterial, venous, and capillary structures. Movements thus excited through changes effected by digestion and chemical action, and thus transmitted, become the motor power through the agency of the nerve ganglia for the contraction and dilatation of the vascular structures. This motion of the heart and arteries thus induced continues in regular rhythm until the animal or person dies, or until the supervention of a lesion in the organism, or the occurrence of the failure in the excitation of the initial mechanical and chemical movements that should be generated in the digestive organs, takes place, through the lack of appropriate ingesta in exact amount and quality for maintaining the function of transmitted motion to the vascular tissues. It will therefore be seen that disease of the gastric and cardiac structures can be prevented or kept largely under control by paying strict attention at all times to rigid measures for diet.—A. P. C.].

NOTE.—[The frequent development of closure or serious organic constriction at the pyloric orifice of the stomach, as is so often met with in practice, should be regarded as a tendency of the digestive organs to return to the condition of the more early ancestral types, or to the condition in which some of the primitive vertebrates had merely a stomach pouch, into which their pabulum for nutrition was received and digested. The egesta, or useless portion, had, therefore, to be extruded through the primitive mouth, by which it had been introduced by the animal, and not

through an anal opening, for such a passage for egesta had not in some of the lower grades been developed. The occurrence in man of such a state should remind him that the changes and relations of the organs in question are most unfortunately departing from that perfect type which has enabled him to take position far above all the other classes and which could only be evolved through the happy preservation of the best of each upward succeeding kind from the simplest vertebrate and through the mammalian class, at the very summit of which man should always endeavor to stand preëminent.—A. P. C.].

Dr. Albert L. Norris made mention of three cases of gastric trouble that had been of serious import. One was the case of a lady of seventy years of age, who had suffered for some six years. For a year past she had suffered from an affection that appeared to be connected with the mesenteric glands. The colon was found to be unduly distended with fæcal matter. Laxatives had been freely tried; free use of injections and the employment of the rectal tube were had recourse to. Finally it became necessary to resort to manual dilatation of the rectum and colon before the large amount of fæcal matter could be dislodged.

Another case was that of a man who suffered from severe gastric pain and vomiting. He was assured, however, by a specialist that his disease was not malignant, because of the presence, as it was claimed, of free hydrochloric acid. The patient then went abroad; profuse vomiting continued to occur after meals, or after the partaking of any kind of food. He required constantly for his care, for this reason, a private nurse. He lost within a few months some sixty pounds in weight. The condition finally led to a fatal termination. The autopsy revealed that the disease was cancerous.

The next case of painful gastric trouble was that of a man upward of sixty years of age. Some months since the condition occurred after partaking at a summer resort of a dinner that had been "left over" after the closure of the hotel. Severe vomiting and agonizing pain followed, and

this persisted whenever any food or drinks were partaken of. The patient went to a hospital, where he received medical treatment, including frequent use of the stomach tube and of rectal injections. Finally, the patient after some four weeks was able through the first partaking of bland nourishment and of preparations of bismuth and other mild stomachics to retain his food upon his stomach and to become free from pain and later to regain materially in weight and strength. So great was the suffering at one time that the patient was ready, if advisable, to submit to surgical measures; this course of proceeding was, however, fortunately deemed unnecessary.

Dr. Irish, in closing the discussion, remarked that so far as the value of the presence of hydrochloric acid is concerned as an evidence of the condition of the stomach's being non-malignant, it should not be regarded as of much importance, because it is only in the later stages of malignant disease that such acid cannot be found. Disease at the pylorus may lead to dilatation and consequent changes of functional activity of the organ. Dilatation of the stomach due to atony of the parietes may lead to alteration of the position; such a condition will often facilitate the invasion of micro-organisms and the consequent inroad of disease. In such cases, when this lesion or alteration has become much advanced, resort to gastro-enterostomy will be most helpful in assisting the necessary means of drainage. This can with benefit be done, if the patient's strength will permit, in those cases after an abdominal section has been made, and yet no malignant tumor or serious organic alteration at the pylorus has been found to have occurred.

The meeting adjourned at 6 P.M., after which the members were invited by the hostess, Mrs. Marcy, to the dining room, where all were bountifully supplied with choice refreshments.

AUGUSTUS P. CLARKE, M.D.
Secretary.

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ERRATA.

Pages 40 and 44 — for Langenbeck, read Professor Karl Langenbuch.

Page 117 — for Dr. John R. Palmer, read Professor John Kinsley Palmer.

Page 158 — for Bilrloth, read Professor Theodor Billroth.

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